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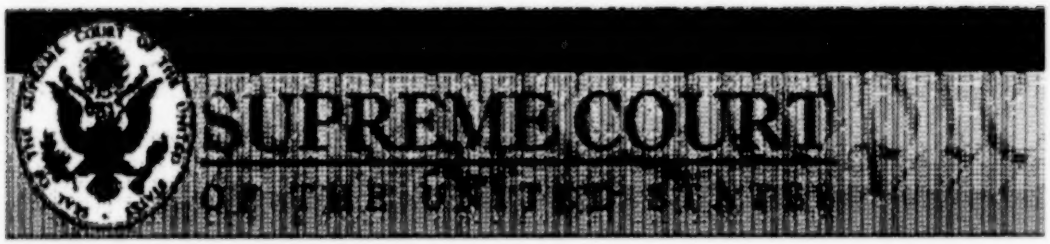

No. 13-1010

Title:	M&G Polymers USA, LLC, et al., Petitioners
	v.
	Hobert Freel Tackett, et al.
Docketed:	February 24, 2014
Linked with 13A753	
Lower Ct:	United States Court of Appeals for the Sixth Circuit
Case Nos.:	(12-3329, 12-3407)
Decision Date:	August 12, 2013
Rehearing Denied:	October 22, 2013

Questions Presented

~~Date~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Jan 10 2014	Application (13A753) to extend the time to file a petition for a writ of certiorari from January 20, 2014 to February 20, 2014, submitted to Justice Kagan.
Jan 16 2014	Application (13A753) granted by Justice Kagan extending the time to file until February 20, 2014.
Feb 20 2014	Petition for a writ of certiorari filed. (Response due March 26, 2014)
Mar 26 2014	Brief of respondents Hobert Freel Tackett, et al. in opposition filed.
Apr 7 2014	Reply of petitioners M&G Polymers USA, LLC, et al. filed.
Apr 9 2014	DISTRIBUTED for Conference of April 25, 2014.
Apr 28 2014	DISTRIBUTED for Conference of May 2, 2014.
May 5 2014	Petition GRANTED limited to Question 1 presented by the petition.
May 9 2014	The time to file the joint appendix and petitioners' brief on the merits is extended to and including July 10, 2014.
Jun 20 2014	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the petitioners.
Jul 8 2014	Consent to the filing ofamicus curiae briefs, in support of either party or of neither party, received from counsel for the respondents.
Jul 10 2014	The time to file the joint appendix and petitioners' brief on the merits is further extended to and including July 17, 2014.
Jul 10 2014	The time to file respondents' brief on the merits is extended to and including September 15, 2014.
Jul 17 2014	Joint appendix filed. (Statement of costs filed)
Jul 17 2014	Brief of petitioners M&G Polymers USA, LLC, et al. filed.
Jul 24 2014	Brief amici curiae of Council on Labor Law Equality and the Society for Human Resource Management filed.
Jul 24 2014	Brief amicus curiae of Goldstein & Russell, P.C., in support of neither party filed.

Jul 24 2014	Brief amici curiae of ERISA Industry Committee and the American Benefits Council filed.
Jul 24 2014	Brief amici curiae of Chamber of Commerce of the United States of America, and the Business Roundtable filed.
Jul 24 2014	Brief amicus curiae of National Association of Manufacturers filed.
Jul 24 2014	Brief amicus curiae of Whirlpool Corporation filed.
Sep 4 2014	SET FOR ARGUMENT on Monday, November 10, 2014.
Sep 8 2014	Record requested from U.S.C.A. 6th Circuit.
Sep 15 2014	Brief of respondents Hobert Freel Tackett, et al. filed.
Sep 15 2014	Record received from U.S.C.A. 6th Circuit is electronic.
Sep 19 2014	CIRCULATED
Sep 22 2014	Brief amici curiae of Labor and Benefits Law Professors filed. (Distributed)
Sep 22 2014	Brief amici curiae of Fox Retiree Committee, et al. filed. (Distributed)
Sep 22 2014	Brief amicus curiae of American Federation of Labor and Congress of Industrial Organizations filed. (Distributed)
Oct 15 2014	Reply of petitioners M&G Polymers USA, LLC, et al. filed. (Distributed)
Nov 10 2014	Argued. For petitioners: Allyson N. Ho, Dallas, Tex. For respondents: Julia P. Clark, Washington, D. C.
Jan 26 2015	Judgment VACATED and case REMANDED. Thomas, J., delivered the opinion for a unanimous Court. Ginsburg, J., filed a concurring opinion, in which Breyer, Sotomayor, and Kagan, JJ., joined.
Feb 27 2015	JUDGMENT ISSUED.

PETITION FOR WRIT OF CERTIORARI

No. 13-1010

In The Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, when construing collective bargaining agreements in Labor Management Relations Act (LMRA) cases, courts should presume that silence concerning the duration of retiree health-care benefits means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds; or should require a clear statement that health-care benefits are intended to survive the termination of the collective bargaining agreement, as the Third Circuit holds; or should require at least some language in the agreement that can reasonably support an interpretation that health-care benefits should continue indefinitely, as the Second and Seventh Circuits hold.

2. Whether, as the Sixth Circuit has held in conflict with the Second, Third, and Seventh Circuits, different rules of construction should apply when determining whether health-care benefits have vested in pure ERISA plans versus collectively bargained plans.

PARTIES TO THE PROCEEDINGS AND RULE 29.6 STATEMENT

The caption of this petition contains all parties to the proceedings.

Petitioner M&G Polymers USA, LLC, is a wholly owned subsidiary of Mossi & Ghisolfi International and is incorporated in West Virginia. Petitioner M&G Polymers USA, LLC Comprehensive Medical Benefits Program For Employees And Their Dependents is a medical benefits program sponsored by M&G. Petitioner The M&G Catastrophic Medical Plan is a medical benefits program sponsored by M&G. Petitioner The M&G Medical Necessity Benefits Program Of Hospital, Surgical, Medical, And Prescription Drug Benefits For Employees And Their Dependents is a medical benefits program sponsored by M&G. Petitioner The M&G Major Medical Benefits Plan is a medical benefits program sponsored by M&G.

TABLE OF CONTENTS

	Page
Questions Presented	i
Parties To The Proceedings And Rule 29.6 Statement	ii
Petition For A Writ Of Certiorari	1
Opinions And Orders Below	1
Statement Of Jurisdiction	2
Statutory Provisions Involved	2
Statement Of The Case	2
Reasons For Granting The Petition	7
I. This Court's Review Is Needed To Resolve An Entrenched Split On How To Construe Collective Bargaining Agreements In Retiree Benefits Cases	10
II. This Court's Review Is Also Needed To Resolve A Related But Distinct Split On Whether The Same Interpretive Rules Should Apply To Both Collective Bargaining Agreements And ERISA Plans In Determining When Benefits Have Vested	17
III. The Proper Interpretation Of Collective Bargaining Agreements And ERISA Plans Is Unquestionably Important And Squarely Presented Here	22
Conclusion	25

TABLE OF CONTENTS—Continued

Page

APPENDIX

Circuit Court Opinion, Aug. 12, 2013 .....Pet. App. 1

District Court Opinion and Order, Feb. 21, 2012 .....Pet. App. 24

Circuit Court Opinion, Apr. 3, 2009.....Pet. App. 88

District Court Opinion and Order, Nov. 21, 2007 .....Pet. App. 121

Circuit Court Denial of Petition for Rehearing, filed Oct. 22, 2013.....Pet. App. 148

29 U.S.C. § 185 .....Pet. App. 150

29 U.S.C. § 1132(a)(1)(B).....Pet. App. 151

TABLE OF AUTHORITIES

Page

CASES:

Abbruscato v. *Empire Blue Cross & Blue Shield*, 274 F.3d 90 (2d Cir. 2001) 18

Allis-Chalmers Corp. v. *Lueck*, 471 U.S. 202 (1985) 22

Am. Fed'n of Grain Millers v. *Int'l Multifoods Corp.*, 116 F.3d 976 (2d Cir. 1997) 11, 14

Anderson v. *Alpha Portland Indus., Inc.*, 836 F.2d 1512 (8th Cir. 1988) 14

Armistead v. *Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991) 13

Barnett v. *Ameren Corp.*, 436 F.3d 830 (7th Cir. 2006) 13

Bender v. *Newell Window Furnishings, Inc.*, 681 F.3d 253 (6th Cir.), *cert. denied*, 133 S. Ct. 436 (2012) 12

Bidlack v. *Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993) 13, 16, 21, 24, 25

Bland v. *Fiatallis N. Am., Inc.*, 401 F.3d 779 (7th Cir. 2005) 13

Bower v. *Bunker Hill Co.*, 725 F.2d 1221 (9th Cir. 1984) 17

Cherry v. *Auburn Gear, Inc.*, 441 F.3d 476 (7th Cir. 2006) 13, 16

Chiles v. *Ceridian Corp.*, 95 F.3d 1505 (10th Cir. 1996) 19

TABLE OF AUTHORITIES—Continued

Page

Cole v. *ArvinMeritor, Inc.*, 549 F.3d 1064 (6th Cir. 2008) 12

Diehl v. *Twin Disc, Inc.*, 102 F.3d 301 (7th Cir. 1996) 13

Gable v. *Sweetheart Cup Co.*, 35 F.3d 851 (4th Cir. 1994) 18

Golden v. *Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996) 13, 21

Int'l Ass'n of Machinists & Aerospace Workers, Woodworkers Div. v. *Masonite Corp.*, 122 F.3d 228 (5th Cir. 1997) 14

Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. *BVR Liquidating, Inc.*, 190 F.3d 768 (6th Cir. 1999) 13, 18, 19

Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. *Cadillac Malleable Iron Co.*, 728 F.2d 807 (6th Cir. 1984) 13

Int'l Union of United Auto., Aerospace & Agric. Implement Workers of Am. v. *Rockford Powertrain, Inc.*, 350 F.3d 698 (7th Cir. 2003) 13

Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. *Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999) 11, 14, 15, 18

Int'l Union, United Auto. Workers of Am. v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983) ..... *passim*

Joyce v. *Curtiss-Wright Corp.*, 171 F.3d 130 (2d Cir. 1999) 15, 16, 18

TABLE OF AUTHORITIES—Continued

Page

Litton Fin. Printing Div. v. *NLRB*, 501 U.S. 190 (1991) 9, 20, 21

Local 174, Teamsters, Chauffeurs, Warehousemen & Helpers of Am. v. *Lucas Flour Co.*, 369 U.S. 95 (1962) 2

Maurer v. *Joy Techs., Inc.*, 212 F.3d 907 (6th Cir. 2000) 13

McCoy v. *Meridian Auto. Sys., Inc.*, 390 F.3d 417 (6th Cir. 2004) 12

Moore v. *Menasha Corp.*, 690 F.3d 444 (6th Cir. 2012), *cert. denied*, 133 S. Ct. 1643 (2013) 12

Murphy v. *Keystone Steel & Wire Co.*, 61 F.3d 560 (7th Cir. 1995) 13

Noe v. *Polyone Corp.*, 520 F.3d 548 (6th Cir. 2008) 11, 12, 13

Pabst Brewing Co. v. *Corrao*, 161 F.3d 434 (7th Cir. 1998) 13

Policy v. *Powell Pressed Steel Co.*, 770 F.2d 609 (6th Cir. 1985) 13

Reese v. *CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) 13

Rossetto v. *Pabst Brewing Co.*, 217 F.3d 539 (7th Cir. 2000) ..... *passim*

Ryan v. *Chromalloy Am. Corp.*, 877 F.2d 598 (7th Cir. 1989) 13

Schreiber v. *Philips Display Components Co.*, 580 F.3d 355 (6th Cir. 2009) 12

TABLE OF AUTHORITIES—Continued

Page

Senior v. *NSTAR Elec. & Gas Corp.*, 449 F.3d 206 (1st Cir. 2006) 17, 19

Senn v. *United Dominion Indus., Inc.*, 951 F.2d 806 (7th Cir. 1992) 13

Smith v. *ABS Indus., Inc.*, 890 F.2d 841 (6th Cir. 1989) 13

Smith v. *Evening News Ass'n*, 371 U.S. 195 (1962) 2

Tackett v. *M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) 1

Tackett v. *M&G Polymers USA, LLC*, 561 F.3d 478 (6th Cir. 2009) 1, 12

Tackett v. *M&G Polymers USA, LLC*, 733 F.3d 589 (6th Cir. 2013) 1, 12

Tackett v. *M&G Polymers USA, LLC*, 853 F. Supp. 2d 697 (S.D. Ohio 2012) 1

Temme v. *Bemis Co.*, 622 F.3d 730 (7th Cir. 2010) 13

Trull v. *Dayco Prods., LLC*, 178 F. App'x 247 (4th Cir. 2006) 19

United Paperworkers Int'l Union v. *Champion Int'l Corp.*, 908 F.2d 1252 (5th Cir. 1990) 17

United Steelworkers of Am. v. *Connors Steel Co.*, 855 F.2d 1499 (11th Cir. 1988) 14

Weimer v. *Kurz-Kasch, Inc.*, 773 F.2d 669 (6th Cir. 1985) 13

TABLE OF AUTHORITIES—Continued

Page

Wood v. *Detroit Diesel Corp.*, 607 F.3d 427 (6th Cir. 2010) 13

Yolton v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006) 12, 14

Zielinski v. *Pabst Brewing Co.*, 463 F.3d 615 (7th Cir. 2006) 13

STATUTES AND OTHER AUTHORITIES:

28 U.S.C. § 1254 2

29 U.S.C. § 185, Labor Management Relations Act 2, 7

29 U.S.C. § 1132 2

Evan Miller, *Retiree Medical Litigation's Dirty Little Secret: "Location, Location, Location!,"* JONES DAY COMMENTARY (Aug. 2009), *available at* http://www.jonesday.com/retiree-medical-litigations-dirty-little-secret-location-location-location-08-04-2009/ 12

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Jeffrey S. Klein & Nicholas J. Pappas, *Recent Developments in Retiree Health Benefits Litigation*, N.Y.L.J., June 5, 2006 23

TABLE OF AUTHORITIES—Continued

Page

Michael S. Melbinger & Marianne W. Culver, *The Battle of the Rust Belt: Employers' Rights to Modify the Medical Benefits of Retirees*, 5 DEPAUL BUS. L.J. 139 (1993) 23

Raymond A. Franklin, *Vesting Retirement Benefits: Revisiting* Yard-Man *and Its Unacknowledged Presumption*, 25 J. CIV. RTS. & ECON. DEV. 803 (2011) 11

Roger C. Siske et al., *What's New in Employee Benefits* (ALI-ABA Course of Study, July 1-5, 2002), WL SH011 ALI-ABA 59 11

PETITION FOR A WRIT OF CERTIORARI

Petitioners M&G Polymers USA, LLC; M&G Polymers USA, LLC Comprehensive Medical Benefits Program For Employees And Their Dependents; The M&G Catastrophic Medical Plan; The M&G Medical Necessity Benefits Program Of Hospital, Surgical, Medical, And Prescription Drug Benefits For Employees And Their Dependents; and The M&G Major Medical Benefits Plan (collectively "M&G") respectfully submit this petition for a writ of certiorari to review the judgment of the U.S. Court of Appeals for the Sixth Circuit.

OPINIONS AND ORDERS BELOW

The order of the court of appeals denying *en banc* rehearing (Pet. App., *infra* 148-149), is unreported. The panel opinion (Pet. App., *infra* 1-23), is reported at 733 F.3d 589 (6th Cir. 2013) ("*Tackett II*"). The opinion and order of the district court (Pet. App., *infra* 24-87) is reported at 853 F. Supp. 2d 697 (S.D. Ohio 2012). The Sixth Circuit's previous opinion (Pet. App., *infra* 88-121), is reported at 561 F.3d 478 (6th Cir. 2009) ("*Tackett I*"). The district court's original opinion and order (Pet. App., *infra* 121-147), is reported at 523 F. Supp. 2d 684 (S.D. Ohio 2007).

STATEMENT OF JURISDICTION

The court of appeals filed its order denying *en banc* rehearing on October 22, 2013. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of § 301 of the Labor Management Relations Act, 29 U.S.C. § 185, and ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), are set forth at Pet. App. 150-152.

STATEMENT OF THE CASE

When employees and unions bargain with employers for retiree health-care benefits, those benefits—and the conditions for receiving them—are set out in collective bargaining agreements. The agreements almost never, however, explicitly address the duration of those benefits. The circuits have badly split over how to construe that contractual silence. This case is an ideal vehicle for resolving that entrenched split—which has been repeatedly acknowledged by courts and commentators alike—on an important, recurring issue of federal law where uniformity is sorely needed, see *Local 174, Teamsters, Chauffeurs, Warehousemen & Helpers of Am.* v. *Lucas Flour Co.*, 369 U.S. 95, 103 (1962), and congressionally required. *Smith* v. *Evening News Ass'n*, 371 U.S. 195, 200 (1962) ("[T]he administration of collective

bargaining contracts [is to be] accomplished under a uniform body of federal substantive law.").

As Judge Posner has put it, the circuits are "all over the lot" in applying different legal rules to determine when retiree health-care benefits in a collective bargaining agreement have vested (and thus cannot be altered by the employer even after the agreement terminates). *Rossetto* v. *Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000). That is no exaggeration. The Sixth Circuit construes silence or ambiguity in a collective bargaining agreement as creating an "inference" or "presumption" that the agreement vests a right to lifetime, contribution-free benefits in the absence of extrinsic evidence to the contrary.

The Third Circuit applies the opposite presumption and requires a clear statement in collective bargaining agreements that the parties intend the benefits to continue indefinitely. And the Second and Seventh Circuits (among others) have staked out a middle ground between those diametrically opposed positions—rejecting both the Sixth Circuit's presumption in favor of vesting and the Third Circuit's presumption against it, and instead requiring at least some language in a collective bargaining agreement that can support interpreting that agreement to provide health benefits indefinitely.

This circuit split has been percolating for years—and the resulting divergence on an important, frequently recurring issue of federal law is intolerable.

Indeed, the rule of construction is frequently outcome-determinative, as it was in this case. The split thus inappropriately encourages forum-shopping and creates magnet jurisdictions for litigation—which, given the rising costs of health care generally and the ever-growing number of retirees particularly, can only increase. This Court's review is needed now to resolve the conflict and restore uniformity on this important and recurring issue of federal law.

Granting the petition would also present the Court with an opportunity to resolve a related split that is similarly outcome-determinative—whether the rules that govern the construction of pure ERISA plans in determining whether benefits have vested should also apply when making the same determination concerning collective bargaining agreements. In conflict with the Second, Third, and Seventh Circuits, the Sixth Circuit applies one legal rule of construction in the former context (a presumption against vesting), and a different legal rule in the latter (a presumption in favor of vesting). That distinction makes no sense, injects needless confusion and uncertainty where uniformity and consistency are needed, and is at odds with this Court's instructions concerning the interpretation of collective bargaining agreements. This Court's review is needed to resolve that conflict, too.

1. Since 2000, M&G has operated a chemical plant in Apple Grove, West Virginia. Before that, Goodyear and Shell operated the plant and employed its workers. Pet. App. 3. A series of collective

bargaining agreements governed the relationship between the workers and their employers at the plant. *Id.* at 3-4.

Included as part of the 2005-2008 collective bargaining agreement was a provision that the employer's share of retirees' health-care costs would be capped annually. Pet. App. 7. The cap provision was also included in a previous cap agreement ("2001 Letter H"), which, in turn, referenced the original cap agreement in the Goodyear collective bargaining agreement ("1991 Letter G"). *Id.* at 130. As relevant here, the agreements obligated the retirees to make contributions toward their health-care costs to the extent those costs exceeded the amount the employer had agreed to pay. *Id.* at 8.

2. After M&G informed retirees in 2006 that they would be required to contribute to their health-care costs—as per the cap agreements in the bargained-for benefit plan—the retirees and their union filed this class action. They alleged that language in the effective collective bargaining agreement referring to a "full Company contribution towards the cost of benefits" gave them a vested right to health-care benefits for life without any contributions. Pet. App. 140. The district court granted M&G's motion to dismiss all of the claims, holding that the retirees were subject to the cap agreements. See *id.* at 147. The retirees and their union appealed.

3. The Sixth Circuit reversed in part, concluding that the retirees had sufficiently pleaded an

intention to vest health-care benefits to survive a motion to dismiss, and remanded for further proceedings. Pet. App. 90. In reaching that conclusion, the Sixth Circuit relied heavily on a prior case—*International Union, United Automobile Workers of America* v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983)—which holds that any retirement benefits obtained through a collective bargaining agreement are presumed to vest. Pet. App. 90.

On remand, the district court conducted a bench trial on liability and ruled that the retirees had a vested right to free health-care benefits for life. Pet. App. 25. According to the district court, the cap agreements were of no moment given the presumption in favor of vesting. *Id.* at 52. The district court issued a permanent injunction barring M&G from collecting retiree medical contributions. *Id.* at 86-87. M&G appealed.

4. Guided once again by the *Yard-Man* presumption, a panel of the Sixth Circuit affirmed. The court approved the district court's "inference" that the language in the collective bargaining agreement vested a right to lifetime, contribution-free benefits in the absence of any extrinsic evidence to the contrary. Pet. App. 2-3. Although the cap agreements were potentially extrinsic evidence against vesting, they were insufficient to counter the retirees' argument once vesting was assumed—because, according to the court of appeals, they were not reproduced in some of the literature discussing the agreement between M&G and its retirees. *Id.* at 14.

A petition for rehearing *en banc* was denied. Pet. App. 148-149.

REASONS FOR GRANTING THE PETITION

The circuits are badly divided on the legal rule of construction that should apply in LMRA cases when construing collective bargaining agreements to determine employers' health-care obligations to retirees. As a result, in what should be an area of federal law that is uniform across the country, the courts of appeals apply different legal rules that are frequently outcome determinative—thus encouraging inappropriate forum-shopping and creating magnet jurisdictions—in retiree health-care benefit litigation. Former employees, like the plaintiffs in this case, who would lose in most jurisdictions can prevail if they are fortuitous enough to have at least one retiree member of their putative class living in Michigan, Ohio, or Kentucky.

When Judge Posner says that the circuits are "all over the lot" in applying different legal rules when interpreting collective bargaining agreements to determine whether health-care benefits have vested—and thus whether retired employees can be required to share in the cost of those benefits—it is not hyperbole. *Rossetto*, 217 F.3d at 543. The Third and the Sixth Circuits conflict most sharply, with the former applying a presumption against vesting and the latter applying a presumption in favor of vesting.

Other circuits, such as the Second and the Seventh, have sought a middle ground—crafting rules of construction that require at least some language in a collective bargaining agreement that can support construing the agreement to provide health benefits to retirees indefinitely. The circuit split has been entrenched for years, so there is no reason to think that further percolation is needed. It is time to resolve the conflict and restore uniformity on an important issue of federal law that, if anything, is recurring even more frequently as health-care costs rise and the number of retirees across the country increases. The issue of whether and when retired employees who receive health-care benefits from their former employers must share the cost of those benefits has never been more pressing.

This Court's review is therefore needed for at least three reasons. First, it would resolve the circuit split over the presumption to be used—if any—when determining whether medical benefits for retirees are vested (and thus cannot be altered by employers). While some circuits hold that such benefits are not vested unless a collective bargaining agreement contains express language to that effect, others emphasize examination of extrinsic evidence and place a thumb on the scale in favor of vesting. The difference is outcome determinative on gateway questions of law and is creating magnet jurisdictions within the federal courts.

Second, the petition presents the Court with an opportunity to resolve a related circuit split on

whether a different legal rule of construction should be applied to collective bargaining agreements than is applied to pure ERISA plans in determining whether health-care benefits have vested. Although several courts of appeals have indicated, in reliance on this Court's instructions concerning the interpretation of collective bargaining agreements generally in *Litton Financial Printing Division* v. *NLRB*, 501 U.S. 190, 207 (1991), that the same legal rule should apply in both contexts, other circuits—including the Sixth Circuit here—use one presumption for collectively bargained plans and the exact opposite one for pure ERISA plans. Those discrepancies are incoherent, at odds with this Court's instruction in *Litton*, and, again, lead to inappropriate forum shopping.

Third, uniformity is exceedingly important in this area of the law given that retiree benefit litigation is only increasing as health-care costs rise and the number of retirees grows ever larger. Billions of dollars and thousands of jobs are riding on uniform interpretations of federal law. Indeed, as the ratio of retirees to active employees continues to increase, that imbalance in the system—long predicted to cripple Social Security—will also undermine the ability of employers to create jobs if health benefits are considered vested in situations unintended by the parties. For all of those reasons, this Court should review (and reverse) the Sixth Circuit's decision in this case.

I. This Court's Review Is Needed To Resolve An Entrenched Split On How To Construe Collective Bargaining Agreements In Retiree Benefits Cases

The circuits have long been divided on how to determine whether health-care benefits for retirees have vested—thereby obligating employers to continue providing those benefits to retirees indefinitely. The conflict is most pronounced in those circuits that deal most with union bargaining—the Second, Third, Sixth, and Seventh. At the root of the conflict is the presumption or inference that a court should make in the face of silence or ambiguity in collective bargaining agreements on the duration of the health-care benefits.

At one end of the spectrum, the Third Circuit mandates that any vesting of health benefits must be "clear and explicit" in the language of the collective bargaining agreement—thereby precluding the use of extrinsic evidence by retirees to prove an alleged intent by an employer to vest the benefits. At the other end of the spectrum is the Sixth Circuit—and, as Judge Sutton has pointed out, although that court denies that it applies any presumption in favor of benefits vesting (including in the instant case), the reality is otherwise:

> Unless a company can point to explicit language in the relevant agreement stating that "retiree benefits" terminate at a particular date or do not vest, the benefits seem to vest as a matter of law. What we continually

> disclaim presuming we continually seem to presume.

Noe v. *Polyone Corp.*, 520 F.3d 548, 568 (6th Cir. 2008) (Sutton, J., concurring in part and dissenting in part); see also Raymond A. Franklin, *Vesting Retirement Benefits: Revisiting* Yard-Man *and Its Unacknowledged Presumption*, 25 J. CIV. RTS. & ECON. DEV. 803, 821-22 (2011) (noting with approval that the Sixth Circuit does, in fact, apply a presumption in favor of vesting). Indeed, the case law and commentary are replete with references to the presumption created by the Sixth Circuit in the seminal case of *Yard-Man, Inc.*, 716 F.2d 1476.[1]

In *Yard-Man*, the plaintiffs brought suit when a factory closed and the company informed the union that retiree health benefits would end when the collective bargaining agreement expired. The agreement was silent on the duration of benefits.

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[1] See, e.g., *Rossetto*, 217 F.3d at 543 ("[*Yard-Man*] holds that benefits are presumed to vest if they are conferred by a collective bargaining agreement * * * *"); *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am.* v. *Skinner Engine Co.*, 188 F.3d 130, 140 (3d Cir. 1999) ("We cannot agree with *Yard-Man* and its progeny that there exists a presumption of lifetime benefits in the context of employee welfare benefits."); *Am. Fed'n of Grain Millers* v. *Int'l Multifoods Corp.*, 116 F.3d 976, 980 n.3 (2d Cir. 1997) (saying *Yard-Man* "apparently presum[ed] that retiree benefits are vested"); Roger C. Siske et al., *What's New in Employee Benefits* (ALI-ABA Course of Study, July 1-5, 2002), WL SH011 ALI-ABA 59, 322 ("The Sixth Circuit *presumes* vesting and requires a clear statement of termination to prove otherwise." (emphasis in original)).

The Sixth Circuit determined that extrinsic evidence should be used to resolve the purported "ambiguity" because, according to the Sixth Circuit, "when the parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." *Id.* at 1482.

As courts and commentators have observed, that inference—known as the "*Yard-Man* presumption"—"necessarily tilted the playing field and in the face of silence or ambiguity, an employer defending itself in the Sixth Circuit must disprove it vested retiree medical benefits." Evan Miller, *Retiree Medical Litigation's Dirty Little Secret: "Location, Location, Location!,"* JONES DAY COMMENTARY (Aug. 2009), *available at* http://www.jonesday.com/retiree-medical-litigations-dirty-little-secret-location-location-location-08-04-2009/; see also *Rossetto*, 217 F.3d at 543 (Posner, J.) ("[*Yard-Man*] holds that benefits are presumed to vest if they are conferred by a collective bargaining agreement * * * *").[2]

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[2] The numbers speak for themselves. The Sixth Circuit has concluded that benefits have vested (or likely vested) in 16 out of 18 reported cases since *Yard-Man* was decided. See *Moore* v. *Menasha Corp.*, 690 F.3d 444 (6th Cir. 2012), *cert. denied*, 133 S. Ct. 1643 (2013); *Bender* v. *Newell Window Furnishings, Inc.*, 681 F.3d 253 (6th Cir. 2012), *cert. denied*, 133 S. Ct. 436; *Tackett I & II*, Pet. App. 88, 1; *Schreiber* v. *Philips Display Components Co.*, 580 F.3d 355 (6th Cir. 2009); *Cole* v. *ArvinMeritor, Inc.*, 549 F.3d 1064 (6th Cir. 2008); *Noe*, 520 F.3d 548; *Yolton* v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006); *McCoy* v.

(Continued on following page)

The case at bar exemplifies how the *Yard-Man* presumption works. The language of the collective bargaining agreement provided for "f[u]ll [c]ompany contribution towards the cost of [health-care] benefits" for employees who met certain requirements—but the agreement was silent as to how long the company was

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Meridian Auto. Sys., Inc., 390 F.3d 417 (6th Cir. 2004); *Maurer* v. *Joy Techs., Inc.*, 212 F.3d 907 (6th Cir. 2000); *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am.* v. *BVR Liquidating, Inc.*, 190 F.3d 768 (6th Cir. 1999); *Golden* v. *Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996); *Armistead* v. *Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991); *Smith* v. *ABS Indus., Inc.*, 890 F.2d 841 (6th Cir. 1989); *Weimer* v. *Kurz-Kasch, Inc.*, 773 F.2d 669 (6th Cir. 1985); *Policy* v. *Powell Pressed Steel Co.*, 770 F.2d 609 (6th Cir. 1985); *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am.* v. *Cadillac Malleable Iron Co.*, 728 F.2d 807 (6th Cir. 1984). Employers won in the Sixth Circuit only 11% of the time. See *Wood* v. *Detroit Diesel Corp.*, 607 F.3d 427 (6th Cir. 2010); *Reese* v. *CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) (opinion by Judge Sutton).

In contrast, during the same time period, the Seventh Circuit concluded that benefits vested in only 3 out of 13 reported cases. See *Temme* v. *Bemis Co.*, 622 F.3d 730 (7th Cir. 2010); *Bland* v. *Fiatallis N. Am., Inc.*, 401 F.3d 779 (7th Cir. 2005); *Diehl* v. *Twin Disc, Inc.*, 102 F.3d 301 (7th Cir. 1996). Employers won in the Seventh Circuit 77% of the time. *Zielinski* v. *Pabst Brewing Co.*, 463 F.3d 615 (7th Cir. 2006); *Barnett* v. *Ameren Corp.*, 436 F.3d 830 (7th Cir. 2006); *Cherry* v. *Auburn Gear, Inc.*, 441 F.3d 476 (7th Cir. 2006); *Int'l Union of United Auto., Aerospace & Agric. Implement Workers of Am.* v. *Rockford Powertrain, Inc.*, 350 F.3d 698 (7th Cir. 2003); *Rossetto*, 217 F.3d 539; *Pabst Brewing Co.* v. *Corrao*, 161 F.3d 434 (7th Cir. 1998); *Murphy* v. *Keystone Steel & Wire Co.*, 61 F.3d 560 (7th Cir. 1995); *Bidlack* v. *Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993); *Senn* v. *United Dominion Indus., Inc.*, 951 F.2d 806 (7th Cir. 1992); *Ryan* v. *Chromalloy Am. Corp.*, 877 F.2d 598 (7th Cir. 1989).

obligated to continue paying for those benefits. Because the parties were contracting for retiree benefits, however, the Sixth Circuit—"[k]eeping in mind the context of the labor-management negotiations identified in *Yard-Man*"—determined it was "unlikely" that the union would have agreed to the terms if they could be altered (but ignored that the benefits were not to be altered *as long as the collective bargaining argument was in place*). Pet. App. 112.

The Sixth Circuit thus inferred (or presumed) that the absence of a durational term—i.e., contractual silence—meant that the benefits were intended to last indefinitely (thus leaving the employer to try to prove a negative). See also *Yolton*, 435 F.3d at 581 (stating that not even a duration-limiting clause in a collective bargaining agreement can prevent vesting unless the clause specifically refers to "retiree benefits themselves"). The Eleventh Circuit has also cited *Yard-Man* with approval and expressly adopted its presumption.[3]

At the other end of the spectrum, the Third Circuit requires a clear statement in the collective

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[3] *United Steelworkers of Am.* v. *Connors Steel Co.*, 855 F.2d 1499, 1505 (11th Cir. 1988) (agreeing with *Yard-Man*). In contrast, the Second, Third, Fifth, Seventh, and Eighth Circuits have expressly rejected the *Yard-Man* presumption. *Am. Fed'n of Grain Millers*, 116 F.3d at 980; *Skinner*, 188 F.3d at 139; *Int'l Ass'n of Machinists & Aerospace Workers, Woodworkers Div.* v. *Masonite Corp.*, 122 F.3d 228, 232 (5th Cir. 1997); *Rossetto*, 217 F.3d at 543; *Anderson* v. *Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988).

bargaining agreement that the parties intended health-care benefits to vest:

> Because vesting of welfare plan benefits constitutes an extra-ERISA commitment, an employer's commitment to vest such benefits is not to be inferred lightly and must be stated in clear and express language.

Skinner, 188 F.3d at 139 (Ackerman, D.J., sitting by designation, joined by Greenberg, J., and Alito, then-J.). In reaching that conclusion, the Third Circuit expressly rejected an "invitation to adopt the presumption enunciated in *Yard-Man*" and concluded instead that "it is not at all inconsistent with labor policy to require plaintiffs to prove their case without the aid of gratuitous inferences." *Id.* at 139, 141 (citation and internal quotation marks omitted). In direct conflict with the Sixth Circuit, the Third Circuit holds that health-care benefits vest only when there is an unambiguous statement in the collective bargaining agreement demonstrating that intent.

The other circuits fall in between the Sixth and Third Circuits—rejecting the *Yard-Man* presumption, yet not going so far as to expressly adopt the Third Circuit's clear-statement rule. In particular, the Second and Seventh Circuits have most clearly recognized the solemnity with which an employer would have taken on such a great responsibility as vesting medical benefits. For example, in *Joyce* v. *Curtiss-Wright Corp.*, 171 F.3d 130, 134 (2d Cir. 1999), the Second Circuit held—in an opinion joined by then-Judge Sotomayor—that retirees must be able to

"identif[y] specific written language that is reasonably susceptible to interpretation as a promise * * * to vest the retirees' health benefits" to survive summary judgment. The Second Circuit thus made clear that, unlike the Sixth Circuit, it would "not infer a binding obligation to vest benefits absent some language that itself reasonably supports that interpretation." *Id.* at 135.

Similarly, the Seventh Circuit presumes that medical benefits for retirees are *not* vested if the collective bargaining agreement is silent as to that term. *Rossetto*, 217 F.3d at 544 ("Our presumption against vesting, it is important to emphasize, kicks in only if all the court has to go on is silence."); see also *Cherry*, 441 F.3d at 481 ("The presumption that healthcare benefits do not exceed the life of an agreement imposes a high burden of proof upon the retirees.").

The seminal case in the Seventh Circuit is *Bidlack* v. *Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993) (*en banc*). There, the *en banc* court stated that an employee's entitlement to benefits expires with the agreement that creates the entitlement unless there is a genuine ambiguity—something beyond silence. *Id.* at 606-07. As Judge Posner elaborated in *Rossetto*, "*Bidlack* enables the employer to fend off a trial without having thought to have included in the contract an express provision limiting the duration of the benefits." *Rossetto*, 217 F.3d at 544.

Other circuits likewise shy away from the *Yard-Man* presumption because "the use of presumptions may interfere with the correct interpretation, under normal LMRA rules, of the understanding reached by the parties." *Senior* v. *NSTAR Elec. & Gas Corp.*, 449 F.3d 206, 218 (1st Cir. 2006). The examination of extrinsic evidence is still allowed under certain circumstances, but the burden of proof regarding vesting remains with the plaintiffs. *Ibid.*[4]

II. This Court's Review Is Also Needed To Resolve A Related But Distinct Split On Whether The Same Interpretive Rules Should Apply To Both Collective Bargaining Agreements And ERISA Plans In Determining When Benefits Have Vested

In addition to the circuit split on the presumption, if any, to be applied in LMRA retiree-benefits cases, the Sixth Circuit's decision in this case implicates a related but distinct circuit split on whether the answer to that question should depend on whether the benefits are provided in a collective bargaining agreement or under a pure ERISA plan.

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[4] Even in "no presumption" circuits, the confusion sown by *Yard-Man* sometimes results in extrinsic evidence being allowed to overcome silence regarding the duration of retiree medical benefits. See, e.g., *United Paperworkers Int'l Union* v. *Champion Int'l Corp.*, 908 F.2d 1252, 1257 (5th Cir. 1990); *Bower* v. *Bunker Hill Co.*, 725 F.2d 1221, 1223-24 (9th Cir. 1984).

The Third and Seventh Circuits have specifically addressed this question and refused to make a distinction between ERISA plans and collective bargaining agreements where interpreting provisions regarding health-care benefits is concerned. See, e.g., *Skinner*, 188 F.3d at 139 (the same rules of construction "apply without regard as to whether the employee welfare benefits are provided under a collective bargaining agreement, [summary plan description], or other plan document"); *Rossetto*, 217 F.3d at 544 ("The distinction between collective bargaining agreements and ERISA plans is not recognized in our cases, and we are not minded to embrace it now and make the law even more complicated than it is."). Likewise, the Second Circuit appears to treat both types of cases the same way. See *Abbruscato* v. *Empire Blue Cross & Blue Shield*, 274 F.3d 90, 97 (2d Cir. 2001); *Joyce*, 171 F.3d at 134.

Other circuits, however, apply different interpretive rules depending on whether a collective bargaining agreement or an ERISA plan is at issue. The Sixth Circuit, for example, has held that a clear-statement rule should apply in ERISA cases but not in LMRA cases like this one. See, e.g., *BVR Liquidating, Inc.*, 190 F.3d at 772-73. The Fourth Circuit has reached the same conclusion. *Gable* v. *Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994) (holding that an employer's waiver of the right to modify benefits must be "clear and express" in ERISA cases because the undertaking there, unlike in LMRA

cases, is voluntary); *Trull* v. *Dayco Prods., LLC*, 178 F. App'x 247, 250 (4th Cir. 2006) (confirming *Gable*).

The First Circuit has noted the conflict as to "whether the same interpretive model should be used in both the ERISA context and the LMRA context," but without taking a stance. *Senior*, 449 F.3d at 217 n.18. Similarly, the Tenth Circuit has stated that the *Yard-Man* presumption might be more appropriate in the realm of collective bargaining than in ERISA. *Chiles* v. *Ceridian Corp.*, 95 F.3d 1505, 1514 (10th Cir. 1996) (abrogated on other grounds). Here, had the Sixth Circuit applied its ERISA rule to the collective bargaining agreement—as the Second, Third, and Seventh Circuits would have done—the outcome of this case would have been different. This Court's review is needed to resolve that conflict, too.

Of particular relevance, the Sixth Circuit has attempted to justify the distinction between health-care benefits provisions in ERISA plans and those in collective bargaining agreements by pointing to *Yard-Man*—which, according to the Sixth Circuit, was "specifically intended to apply in the context of a collective bargaining agreement." *BVR Liquidating*, 190 F.3d at 773. This is in keeping with *Yard-Man*'s rationale that an "inference" should be made that collectively bargained-for retiree health-care benefits are vested because "it is unlikely that such benefits, which are typically understood as a form of delayed compensation or reward for past services, would be left to the contingencies of future negotiations." *Yard-Man*, 716 F.2d at 1482.

Judge Posner, however, has pointed out that if anything, "a reversal of these presumptions would make better sense—that if the union negotiated for the benefits, they would surely appear in the collective bargaining agreement." *Rossetto*, 217 F.3d at 543-44; see also Gregory Parker Rogers, *Rethinking* Yard-Man: *A Return to Fundamental Contract Principles in Retiree Benefits Litigation*, 37 EMORY L.J. 1033, 1067 (1988) ("If the union was serious about getting benefits for its retirees beyond the end of the contract as 'deferred compensation,' then almost certainly it would demand a clause in the collective bargaining agreement to that effect.").

In addition to blinking the reality of collective bargaining negotiations, the Sixth Circuit's dueling presumptions also conflict with this Court's teaching in *Litton* that in the collective bargaining context, the written words of the contract must indicate that the employer intended for a benefit to extend beyond the life of the collective bargaining agreement. 501 U.S. at 207. In *Litton*, this Court held that "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement" unless the "collective-bargaining agreement provides *in explicit terms* that certain benefits continue after the agreement's expiration." *Ibid.* (emphasis added). Under *Litton*, then, silence should not be held against the employer, as the Sixth Circuit does. Benefits can only continue past the life of the agreement if there are explicit terms in the agreement indicating so.

The extent to which *Litton* demands a clear-statement rule in the context of retiree health-care benefits, however, is unsettled. The Third Circuit relied heavily on *Litton* in holding that the same presumption against vesting should apply to both collective bargaining agreements and ERISA plans but the Sixth Circuit has, predictably, rejected that approach. In *Golden*, 73 F.3d at 655, the Sixth Circuit opined that "courts, through rules of contract interpretation, can find that rights accrue or vest under the agreement even if they are not explicitly set out in the agreement."

As Judge Easterbrook pointed out in dissenting from Judge Posner's majority opinion in *Bidlack*, however, *Litton*'s insistence on "explicit terms" does not preclude parties from agreeing to unchanging benefits "[b]ut the presumption is and always has been that benefits mentioned in a collective bargaining agreement do not vest." *Bidlack*, 993 F.2d at 616-17 (Easterbrook, J., dissenting). Thus under *Litton*, silence in a collective bargaining agreement concerning the duration of a benefit cannot be enough to give rise to a vesting claim—silence is plainly not the "explicit language" required by *Litton*. Ambiguity, however, may present a closer question—and extrinsic evidence could be admissible in that circumstance. But what cannot be correct under *Litton* is that the mere existence of collective bargaining creates an "inference" of vesting, as the Sixth Circuit has repeatedly held (even as it has vigorously denied doing so). It is time to retire *Yard-Man* and bring the

Sixth Circuit (and others) into line with this Court's precedent.

III. The Proper Interpretation Of Collective Bargaining Agreements And ERISA Plans Is Unquestionably Important And Squarely Presented Here

Retiree-benefit plans are increasingly subject to litigation. See *supra* note 2. And health-benefit issues will only increase under the Patient Protection and Affordable Care Act as the Nation's health-care system undergoes seismic changes. What is at stake in the legal rules applied to resolve cases like the one at bar is nothing less than billions of dollars and potentially thousands of jobs. And more than ever, retirees, labor unions, and employers all need predictable legal rules in the health-benefits context. The problem is particularly acute in states where collective bargaining agreements are commonplace—and it requires this Court's review to resolve the conflict and restore uniformity on these exceptionally important, recurring issues of federal law.

It is intolerable that simply by providing the same benefits through a collectively bargained plan, rather than an ERISA plan, employers should find themselves subject to a patchwork of differing (and frequently outcome-dispositive) legal rules. That state of affairs runs contrary to both congressional intent and common sense—and requires this Court's review to resolve. *Allis-Chalmers Corp.* v. *Lueck*, 471

U.S. 202, 209 (1985) (holding that § 301 is a "congressional mandate to the federal courts to fashion a body of federal common law to be used to address disputes arising out of labor contracts").

This case presents a textbook example of the problem—and is thus an ideal vehicle for resolving it. There is no factual dispute that the collective bargaining agreement at issue was silent on the duration of the health-care benefits conferred. In the Third Circuit, where duration must be explicitly mentioned in a collective bargaining agreement, M&G certainly would have prevailed. In the Second and Seventh Circuits, where there must be some textual ambiguity other than silence to permit the parties to introduce extrinsic evidence to prove an intent to vest, M&G likewise would have prevailed. Not so in the Sixth Circuit, which assumed that benefits vest simply by virtue of the recipients being retirees (and which looked to extrinsic evidence to create ambiguity, to boot).

Not surprisingly, the Sixth Circuit has become a magnet for such litigation—leading to the intolerable situation that the outcome of these cases can be more dependent on where they are brought than on their actual merits. See Jeffrey S. Klein & Nicholas J. Pappas, *Recent Developments in Retiree Health Benefits Litigation*, N.Y.L.J., June 5, 2006, at 3 (noting that, after *Yard-Man*, medical-benefit vesting cases are dependent not only on the facts of the case "but also on the governing judicial precedent in the jurisdiction where the case is filed"); Michael S. Melbinger

& Marianne W. Culver, *The Battle of the Rust Belt: Employers' Rights to Modify the Medical Benefits of Retirees*, 5 DEPAUL BUS. L.J. 139, 161 (1993) (highlighting facts that portend races to the courthouse in different jurisdictions).

This case also presents an ideal opportunity for this Court to address the entrenched circuit splits that have resulted from the Sixth Circuit's *Yard-Man* presumption. There are no procedural or factual issues here—only pure questions of law that are outcome-determinative. Furthermore, although this Court has previously denied certiorari in cases raising the same issues, there can be little doubt now that the splits will not resolve themselves. The respective positions have been analyzed and staked out by the various circuits and further percolation would not aid the Court's analysis or resolution of the issues.

This Court's review is badly needed to provide clarity to employers, employees, unions, and retirees across the country on an exceptionally important issue of federal law that has immense practical consequences—especially as employers face increasing health-care costs and rising numbers of retirees. "Employers with national operations are subject to multiple and inconsistent rules, compounded by the uncertainty inherent in sending big-stakes questions to the constantly changing panels that are juries." *Bidlack*, 993 F.2d at 620 (Easterbrook, J., dissenting). The current hodgepodge of legal rules and dueling presumptions is driving up litigation and employer

costs alike—ultimately to the detriment of workers and the economy, too. As Judge Easterbrook has put it, "[u]ncertainty now reigns * * * * Uncertainty never promotes industry." *Ibid.* This Court should grant the petition, resolve the conflicts, and restore uniformity on these important, recurring issues of federal law.

CONCLUSION

The petition for a writ of certiorari should be granted.

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733 F.3d 589

Hobert Freel TACKETT, Woodrow K. Pyles, United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, and Harlan B. Conley, Plaintiffs-Appellees/Cross-Appellants,

v.

M & G POLYMERS USA, LLC, M & G Polymers USA, LLCComprehensive Medical Benefits Program for Employees and their Dependents, M & G Catastrophic Medical Plan, M & G Medical Necessity Benefits Program of Hospital, Surgical, Medical, and Prescription Drug Benefits for Employees and their Dependents, and M & G Major Medical Benefits Plan, Defendants-Appellants/Cross-Appellees.

Nos. 12-3329, 12-3407.

United States Court of Appeals,
Sixth Circuit.

Argued: March 15, 2013.
Decided and Filed: Aug. 12, 2013.
Rehearing and Rehearing En Banc
Denied Oct. 22, 2013.

ARGUED: Philip A. Miscimarra, Morgan, Lewis & Bockius LLP, Chicago, Illinois, for Appellants/Cross-Appellees. David M. Cook, Cook & Logothetis, LLC, Cincinnati, Ohio, for Appellees/Cross-Appellants. ON BRIEF: Philip A. Miscimarra, Morgan, Lewis & Bockius LLP, Chicago, Illinois, Christopher A. Weals, Morgan, Lewis & Bockius LLP, Washington, D.C., for Appellants/Cross-Appellees. David M. Cook, Jennie G.

Arnold, Claire W. Bushorn, Cook & Logothetis, LLC, Cincinnati, Ohio, for Appellees/Cross-Appellants.

Before: KEITH, MARTIN, and COLE, Circuit Judges.

OPINION

COLE, Circuit Judge.

Defendants-Appellants Cross-Appellees M & G Polymers USA, LLC ("M & G") and associated health plans appeal the permanent injunction granted by the district court in favor of Plaintiffs-Appellees Cross-Appellants, retirees and dependents of retirees from an M & G plant and the union that currently represents plant employees.[1] Plaintiffs brought a class action suit against Defendants after M & G announced that Plaintiffs would be required to make health care contributions. After a bench trial, the district court found Defendants liable for violating both a labor agreement and an employee welfare benefit plan. The district court issued a permanent injunction ordering Defendants to reinstate Plaintiffs to the current versions of the benefits plans they were enrolled in until 2007 to receive health care for life without contributions.

While Defendants ask this Court to reverse the liability determination and injunction, Plaintiffs request this Court to reinstate certain Plaintiffs to the pre-2007 versions of their benefits plan. Defendants

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[1] Hobert Freel Tackett; Woodrow K. Pyles; Harlan B. Conley; and United Steel, Paper & Forestry, Rubber, Manufacturing, Energy, Allied Industrial & Service Workers International Union.

argue that the district court clearly erred when it found that (1) certain letters requiring retiree contributions to health care costs were not a part of Plaintiffs' labor agreements; and (2) Plaintiffs' right to lifetime health care vested at retirement. Plaintiffs cross-appeal, arguing that, although the district court correctly held that their right to lifetime contribution-free benefits vested, the district court erred by restoring them to the current versions of their benefits plan, as opposed to the pre-2007 versions. We affirm the judgment of the district court.

I.

The named plaintiffs are Ohio residents and retirees from the Apple Grove, West Virginia Point Pleasant Polyester Plant ("Apple Grove"), which M & G has owned since 2000. From 1992 to 2000, Apple Grove was owned by Shell Chemical Company ("Shell"). Prior to 1992, it was owned by The Goodyear Tire & Rubber Company ("Goodyear").

Plaintiffs and similarly situated retirees belong to Local Union 644 ("Local 644") of the United Steel, Paper & Forestry, Rubber, Manufacturing, Energy, Allied Industrial & Service Workers International Union, AFL-CIO ("USW"), which currently represents Apple Grove employees. Prior to 1995, Local 644 belonged to the United Rubber Workers ("URW"), which merged with the USW in 1995. Over the years that Apple Grove was owned by Goodyear, Shell and M & G, Local 644 entered into a number of labor agreements.

Typically, the union as a whole—first the URW and later the USW—would negotiate a "master"

agreement with the employer. Individual plants would adopt an agreement in one of three ways: (1) some plants directly participated in the "master bargaining" with the employer and entered into the master agreement itself; (2) some plants separately adopted "me-too" agreements that were the same as the master agreement; and (3) some plants, including Apple Grove according to Plaintiffs, negotiated "me-too with exceptions" agreements, meaning that they adopted agreements based on the master agreement, but with certain exceptions or differences. M & G, however, claims that Apple Grove was a "'me-too' location[]" that "had a consistent practice of applying the 'master agreement' settlement year-after-year."

While Apple Grove was owned by Goodyear, Goodyear and Local 644 entered into a collective bargaining agreement ("1991 CBA") effective November 6, 1991, to November 6, 1994, and a collectively bargained Pension, Insurance and Service Award Agreement effective May 15, 1991, to May 15, 1994, ("1991 Master P & I Agreement"). The 1991 Master P & I Agreement described, among other things, the health care benefits that retirees could expect to receive. A "side letter" ("1991 Letter G") was part of the 1991 Master P & I Agreement for certain URW locals, but not necessarily all. The 1991 Letter G stated:

> If the average annual cost of health care benefits [per retiree who retires on or after May 1, 1991, including his/her spouse] exceeds [$10,500 for retirees (including surviving spouses) under age 65 and $4200 for

> retirees (including surviving spouses) over age 65], the cost in excess * * * shall be allocated evenly to all retired employees (including surviving spouses) in such group.

The 1991 Letter G also specified that the required contributions would not begin until July 1, 1997.

Also, a Summary Plan Description ("SPD"), effective as of May 15, 1991, stated that the "Company has established a required maximum average annual company cost per retiree for medical coverage," and set this maximum at $10,500 per year for each retiree under age 65 and $4,200 per year for each retiree over age 65 (surviving spouses included). It provided that the cost of any excess above the maximums would be allocated among all members of the group of retirees evenly, and that contributions would not begin until at least July 1, 1997.

In 1992, Shell bought Apple Grove and, in 1993, formally adopted the Goodyear benefit plans previously in effect at the plant. In 1994, Shell and the URW and some URW locals entered into the "1994 Master P & I Agreement" which, for some URW locals, included a side letter: "1994 Letter G." The same year, Shell and Local 644 entered into another collective bargaining agreement, the "1994 CBA," effective November 6, 1994, to November 6, 1997.

On May 9, 1997, Shell and the USW (the current union) entered into the "1997 Goodyear Master P & I Agreement," which was effective until May 9, 2003. This agreement included, for some USW locals, a side

letter: "1997 letter H." On November 6, 1997, Shell and the USW and Local 644 entered into the "1997 CBA," effective until November 6, 2000.

M & G bought Apple Grove in 2000. In September 2000, M & G and the USW and Local 644 entered into the "2000 CBA." A P & I Agreement, effective on Nov, 6, 2000, accompanied the 2000 CBA. In 2003, M & G and the USW, acting on behalf of Local 644, began bargaining over the next collective bargaining agreement. The bargaining continued through August 2005, and included more than sixty days of negotiations. On August 9, 2005, M & G and the USW on behalf of Local 644 entered the "2005 CBA," to be effective August 9, 2005, to November 5, 2008. The 2005 CBA included Letter of Understanding 2003-6 ("LOU 2003-6"). All Plaintiffs were, prior to retirement, active employees under one or more of the above CBAs.

The 2000 P & I contained the following language:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan * * * whose full years of attained age and full years of attained continuous service * * * at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of [health-care] benefits * * * * Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2%

> for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health care] benefits * * *. Failure to pay the required medical contribution will result in cancellation of coverage.

The 1994 and 1997 P & I Agreements contained similar language.[2] Each P & I Agreement, once reached, was printed as a booklet and distributed to local union members.

The side letters were also known as "cap letters" because they "capped" the company's contribution towards the cost of retiree health care benefits. 1991 Letter G was the first such letter. 1994 Letter G, 1997 Letter H and LOU 2003-6 were also "cap letters," similar to 1991 Letter G, specifying various

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[2] The 1994 and 1997 Master P & Is contain nearly identical language, except instead of referencing the "1993 Pension plan," they reference the "1950 Pension Plan." The 1991 P & I states:

> Employees who retire with 10 or more years of continuous service and who are eligible and receiving a monthly pension under the 1950 Pension Plan for a pension (other than a deferred vested pension), shall receive the benefits described in this [section]; provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

coverage maximums and "bite dates" when required contributions would begin. The letters were not reproduced in P & I booklets and allegedly not ratified as part of the local agreement.

In December 2006, M & G announced that it would begin requiring retirees to contribute to the cost of their medical benefits. *See Tackett v. M & G Polymers, USA, LLC (Tackett I)*, 561 F.3d 478, 480 (6th Cir. 2009) (per curiam). At the time, each Plaintiff was enrolled in either (1) the Medical Necessity Plan; (2) the Catastrophic Plan; or (3) the Comprehensive Plan. Some Plaintiffs refused to pay premiums and were dropped from coverage. Other Plaintiffs paid premiums, even if under protest, and remained enrolled in their plans.

Plaintiffs filed suit on February 9, 2007. Plaintiffs contended that the promise of a "full Company contribution towards the cost of [health care] benefits" in the CBAs provided them with a vested right to receive health care benefits in retirement without making any contributions. *Tackett I*, 561 F.3d at 482. Defendants contended that various other agreements between Local 644 and the successive employers, specifically the cap letters, limited that promise.

Plaintiffs' amended complaint stated three claims: (1) violation of labor agreements under § 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185(a); (2) violation of an employee welfare benefit plan under § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"),

29 U.S.C. § 1132(a)(1)(B); and (3) breach of fiduciary duty under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3).

The district court granted Defendants' motion to dismiss on all three counts and Plaintiffs appealed to this Court. We affirmed the dismissal of the breach of fiduciary duty claim, but reversed the dismissals of and remanded the first two claims. *Tackett I*, 561 F.3d at 493. Then, the district court conducted a bench trial on the issue of liability.

Eight witnesses testified at the bench trial. For Plaintiffs: two Apple Grove retirees (Woodrow Pyles and Hobert Tackett), and four former union negotiators (Ron Hoover, Randall Moore, Karen Shipley, and Brian Wedge). For Defendants: M & G's Human Resources director for Apple Grove (Kimm Korber), and a former M & G negotiator (Robert Long). The district court opinion amply summarizes their testimonies. *See Tackett v. M & G Polymers USA, LLC*, 853 F. Supp. 2d 697, 703-09 (S.D. Ohio 2012).

After the trial, the district court found in favor of Plaintiffs on both remaining claims. Plaintiffs moved for a permanent injunction to reinstate their lifetime contribution-free health care benefits. The district court ordered that Plaintiffs be reinstated, but to the post-2007 versions of their plans.

Defendants appeal the liability ruling and, accordingly, seek to have the permanent injunction dissolved. Plaintiffs appeal the portion of the permanent injunction that orders retirees and dependents

previously enrolled in the pre-2007 Comprehensive Plan or Catastrophic Plan to be enrolled in the current Comprehensive Plan instead of being reinstated to the pre-2007 Comprehensive Plan.[3]

II.

After a bench trial, we review the district court's factual findings for clear error and its legal conclusions de novo. *Lincoln Elec. Co. v. St. Paul Fire & Marine Ins. Co.*, 210 F.3d 672, 683 (6th Cir. 2000) (citation omitted). We review the scope of a permanent injunction for an abuse of discretion. *Lee v. City of Columbus*, 636 F.3d 245, 249 (6th Cir. 2011) (citation omitted). "The district court abuses its discretion when it relies on clearly erroneous findings of fact, uses an erroneous legal standard, or improperly applies the law." *See United States v. Lawrence*, 555 F.3d 254, 261 (6th Cir. 2009) (quotation omitted).

The liability determination in this case hinges on whether the collectively bargained agreements between Plaintiffs and Defendants vested in Plaintiffs a right to lifetime no-contribution health care benefits. A health care plan is a welfare benefit plan which, unlike a pension plan, does not vest automatically, but only "if the parties so intended when they executed the applicable labor agreements." *See Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008).

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[3] Plaintiffs previously enrolled in the Medical Necessity Plan do not object to being enrolled in the current version.

To vest, in this context, means to remain binding "beyond the expiration of the collective bargaining agreement." *See UAW v. Yard-Man, Inc.*, 716 F.2d 1476, 1479 (6th Cir. 1983). Substantive federal law governs the analysis. *See id.*

A.

In *Tackett I*, we said that the P & I language indicated a desire to vest benefits:

> First, the "full Company contribution" language suggests that the parties intended the employer to cover the full cost of health-care benefits for those employees meeting the age and term-of-service requirements. Keeping in mind the context of the labor-management negotiations identified in *Yard-Man*, [716 F.2d 1476 (6th Cir. 1983)] we find it unlikely that Plaintiff USW would agree to language that ensures its members a "full Company contribution," if the company could unilaterally change the level of contribution. The CBA has no limitation on the amount of a company contribution and if the Defendants' argument were accepted, the company presumably could lower the contribution to zero without violating this language. Such a promise would be illusory.
>
> Second, the limiting language, "[e]mployees will be required to pay the balance of the health care contribution," follows the provision requiring contributions by those retirees who had not attained the requisite seniority

> points. From the placement of this language, we can reasonably infer that it did not apply to all retirees, but only to those retirees who had not attained the requisite seniority points.
>
> Third, the collective bargaining agreement tied eligibility for health-care benefits to pension benefits. This is another factor indicating that the parties intended the health care benefits to vest upon retirement.

561 F.3d at 490. Subsequently, we described this analysis as "[t]he determination above that the parties intended health care benefits to vest [which] carries over to the ERISA § 502(a)(1)(B) claim." *Id.* at 491. According to the district court, "[b]y presenting the intended vesting as a fact leading to the result that Plaintiffs had presented a plausible claim, the appellate court pointedly issued a conclusion instead of merely recognizing a credible possibility."

Although we applied general principles of contract interpretation in *Tackett I*, *see* 561 F.3d at 489-90, we did not apply them to a complete factual record as would have been necessary for a conclusive determination of the vesting issue. For example, it was a matter of factual dispute whether the side letters were part of the CBA. If part of the CBA, they would have been relevant to the issue of vesting. However, this Court found them to be "extrinsic" to the Rule 12(b)(6) analysis because they were not part of the pleadings. *See id.* at 487 n.6 (citing approvingly the district court's "note[ ]" that the "'unusual'

procedural posture of the case * * * allowed the court to consider the Letter Agreements in a [Rule] 12(b)(1) motion but not in the [Rule] 12(b)(6) motion.").

Tackett I also limited its "determination[s]" to the Rule 12(b)(6) context in two other ways. First, prior to embarking on the Rule 12(b)(6) analysis, which contains the language relied on by the district court, the *Tackett I* panel pointedly declined to convert Defendants' Rule 12(b)(6) motion into a Rule 56 motion for summary judgment. *See id.* at 487-88. The panel concluded that it "w[ould] not consider matters extrinsic to the pleadings and [would] proceed to review the district court's Rule 12(b)(6) analysis." *Id.* at 488. Second, the panel acknowledged the possibility that the district court might determine on remand that Plaintiffs did not have vested benefits. *See id.* at 493 n.11. For these reasons, *Tackett I* did not conclusively determine that Plaintiffs' retirement benefits had vested.

B.

Fortunately, the district court's determination that benefits had vested did not rest solely on a misinterpretation of *Tackett I*. The district court also performed its own analysis of the facts, which led it to conclude that the cap letters were not part of the Apple Grove CBA and that vesting occurred. The district court considered the following evidence, in addition to the P & I agreement: (1) documents indicating an agreement between the union and the

employers to "cap" health benefits, several "side" letters and the SPD, which were part of the "master" agreements; (2) P & I booklets circulated to Apple Grove employees that described, among other things, retiree benefits, and did not contain any "capping" documents; (3) testimony from individuals involved in "master" negotiations, Apple Grove local negotiations or both. *See Sw. Williamson Cnty. Cmty. Ass'n, Inc. v. Slater*, 173 F.3d 1033, 1036 (6th Cir. 1999) (citing *Dandridge v. Williams*, 397 U.S. 471, 475 n.6, 90 S. Ct. 1153, 25 L. Ed. 2d 491 (1970)) (holding that an appellate court can affirm district court on alternate grounds supported by the record).

Whether the cap letters were part of Apple Grove's CBAs is an issue of fact, reviewable only for clear error. *See Thomasville Furniture Indus., Inc. v. JGR, Inc.*, 3 F. App'x 467, 473 (6th Cir. 2001) ("Whether a given document is part of a written contract is a question of fact." (citing *Greenberg v. The Life Ins. Co. of Va.*, 177 F.3d 507, 516 (6th Cir. 1999) (additional citation omitted))). The district court did not clearly err in finding the cap agreements inapplicable to Apple Grove.

M & G argues that the conduct of union representatives from 1991 to 2005 was inconsistent with the district court's interpretation of the CBAs and P & Is as not including the cap letters. M & G claims that even the testimony of Plaintiffs' witnesses demonstrates that union representatives did not believe there was a vested right to lifetime no-contribution benefits for Apple Grove retirees. The

most persuasive evidence cited by M & G is the "internal union conversations" that appear to indicate that at least some union representatives believed the cap letters to apply. Moore testified that he had been told by some local committee members that the 1997 Letter H applied, but that, despite "seach[ing] extensively," he could not find "any document indicating it had been adopted or ratified by the local." Hoover advised Moore and Shipley that "if" they used "a letter like Goodyear," they should "move the damn dates out or your retirees are going to get hit with a premium." Moore testified that Shipley told him that she was told "to be aware that there was a Letter H."

Although these statements certainly have the potential to imply that cap agreements were applicable, they need not be dispositive. Hoover participated in the master bargaining, which undisputedly included cap letters. However, he did not participate in local bargaining for Apple Grove, and the fact that he told some Apple Grove negotiators about the cap letters in the master agreement does not demonstrate that they applied to Apple Grove, especially since he qualified his advice with the word "if." At best, Hoover and Moore acknowledged the possibility that the cap letters applied to Apple Grove, but neither had any firm knowledge or documentation of the letters' applicability. In the face of such ambiguity, the district court did not clearly err by concluding that the letters did not apply to Apple Grove.

In sorting through conflicting recollections of negotiations, the district court noted that several

parties with authority to bind M & G and the union rejected or disputed cap letter applicability. M & G objects to the district court's "focus on what union entity can 'bind' the union" as an error of law. M & G argues that "[q]uestions regarding who can 'bind' the union * * * are unrelated to the probative value of evidence regarding what local bargaining committee members have done or said about past bargaining or past agreements."

The district court did not, as M & G claims, treat statements of those with "binding authority" as dispositive, but it did appear to weigh these statements more heavily than statements from those without binding authority. Credibility determinations are a matter of fact and the district court's determination receives great deference. *See United States v. Esteppe*, 483 F.3d 447, 452 (6th Cir. 2007). It is not unreasonable to infer that a party with authority to bind would be more likely to be informed regarding important documents.

M & G describes the district court as "find[ing] that the collective bargaining agreement was enforceable only as to specific items described during ratification votes," and cites *Teamsters Local 589 (Jennings Dist., Inc.)*, 349 N.L.R.B. 124, 128 (2007) for its argument that such a "deficiency" does not void union ratification of an agreement. The district court did not, as M & G suggests, use the non-presentation of the cap letters as an "escape mechanism" from an otherwise-ratified agreement. Rather, Apple Grove employees' lack of knowledge regarding the cap

letters was cited as an example of absence of evidence of the letters' inclusion in the Apple Grove agreements. As Plaintiffs point out, this was "but one piece of evidence among many."

Similarly, the district court did not err by considering the lack of awareness of the cap letters on the part of Shell's accountants and M & G's actuaries. The district court merely noted the absence of the type of evidence of the cap letters' applicability to Apple Grove that one would expect to see if Defendants' account of events was credible. The district court properly treated such lack of awareness as circumstantial, not "dispositive," evidence that the cap letters did not apply to Apple Grove.

M & G argues that LOU 2003-6, which permitted collecting contributions from retirees whose insurance costs exceeded the caps set forth in the 2001 Letter H, was applicable to all Plaintiffs, including those who retired prior to August 9, 2005, because employers may lawfully implement portions of a final offer after an impasse is reached in bargaining. *See United Paperworkers Int'l Union v. NLRB*, 981 F.2d 861, 866 (6th Cir. 1992) (per curiam).

In early 2004, when LOU 2003-6 was unilaterally implemented by M & G, any portions affecting then-retirees' rights were not lawfully implemented because the ability to take unilateral action post-impasse only applies to mandatory topics of bargaining, *see Taylor Warehouse Corp. v. NLRB*, 98 F.3d 892, 902 (6th Cir. 1996), while retiree benefits are a

permissive topic. *See Yard-Man*, 716 F.2d at 1482. Furthermore, in August of 2005, when LOU 2003-6 became part of the 2005 CBA, it could not be applied to pre-August 9, 2005 retirees because their benefits had already vested, as described below.

Finally, M & G cites the SPD as evidence that retiree benefits were capped. However, SPDs "are not legally binding, nor parts[] of the benefit plans themselves." *Engleson v. Unum Life Ins. Co. of Am.*, 723 F.3d 611, 620, No. 12-4049, 2013 WL 3336741, at *7 (6th Cir. 2013) (quotation marks and citations omitted). Although the district court was permitted to consider the SPD as "extrinsic evidence," *see Moore v. Menasha Corp.*, 690 F.3d 444, 456 (6th Cir. 2012), we cannot say that the district court clearly erred by declining to find it persuasive.

C.

Given that the district court did not clearly err in finding that the cap letters were not part of the pre-2005 CBAs, the district court also did not clearly err in interpreting the pre-2005 CBAs as vesting a right to lifetime contribution-free benefits in the pre-August 9, 2005 retirees. Interpretation of a CBA is a matter of law only when the parties rely wholly on the terms of the CBA and do not present any extrinsic evidence of intent. *See Yard-Man*, 716 F.2d at 1480 n.1. In this case, the determination of intent becomes a mixed question of both law and fact, for which the standard of review is clear error. *See id.*

We must determine whether the parties intended benefits to vest by applying traditional rules of contract interpretation, as long as doing so is consistent with federal labor policies. *Id.* at 1479. To interpret the language of a CBA, we must:

> (1) "look to the explicit language," (2) evaluate that language "in light of the context" that led to its use, (3) "interpret each provision * * * as part of the integrated whole," (4) construe each provision "consistently with the entire document and the relative positions and purposes of the parties," (5) construe the terms "so as to render none nugatory" and to "avoid illusory promises," (6) look to other words and phrases in the document to resolve ambiguities, and (7) "review the interpretation * * * for consistency with federal labor policy."

Tackett I, 561 F.3d at 489 n.7 (quoting *Yard-Man*, 716 F.2d at 1479-80).

Though *Tackett I* was not conclusive on the vesting issue as a whole, it is conclusive on a narrower question: that of whether the quoted "explicit language" of the CBA, in the absence of "other words and phrases in the document" such as the cap letters, indicates an intent to vest. *Tackett I* interpreted the quoted language of the CBA, standing alone, as indicating intent to vest and this interpretation bound the district court, while leaving it free to make its own conclusion about the ultimate question of vesting based on other portions of the document,

extrinsic evidence or both. *See, e.g.*, *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 579 (6th Cir. 2006) ("When ambiguities exist, courts may look to other provisions of the document and other extrinsic evidence." (citation omitted)). The qualifying language in *Tackett I* implied that the CBA language, though indicating intent to vest, contained enough ambiguity to permit examination of such additional evidence.

The district court's presumption that, in the absence of extrinsic evidence to the contrary, the agreements indicated an intent to vest lifetime contribution-free benefits was in accordance with both *Tackett I* and the CBA language promising a "full contribution" to qualifying employees. To the extent that vesting was presumed, it was not the district court that, *sua sponte*, shifted the burden of proof, but rather the language of the CBA and its linkage of health care benefits to pension benefits, *see Reese v. CNH America LLC*, 574 F.3d 315, 322 (6th Cir. 2009), that led to the conclusion that retirees had a vested right to health care benefits and, in the absence of evidence to the contrary, a vested right to contribution-free health care benefits. Having reached the conclusion that benefits were vested, it was then reasonable for the district court to conclude that those benefits could not be bargained away without retiree permission.

M & G points out that we have previously said that vesting of contribution-free health care benefits should not be presumed "simply * * * because none of the CBA documents provided that retirees 'would be

required' to pay premium contributions." *Wood v. Detroit Diesel Corp.*, 213 F. App'x 463, 466 (6th Cir. 2007). But in this case, the 2000 CBA, and the others with similar language, specifically promised a "full Company contribution" towards health care benefits. Furthermore, in *Detroit Diesel*, there were applicable "Supplemental Agreements" advising retirees that they "'may be required to make monthly contributions'" and that "rates of payment, coverages, and terms and conditions of the program were all subject to change by Detroit Diesel at any time on reasonable notice." *Id.* at 467. In the present case, the analogous capping agreements are not applicable. Finally, even in *Detroit Diesel*, where there was weaker evidence of affirmative intent to vest and stronger anti-vesting evidence, this Court still concluded that the plaintiffs had sufficient likelihood of success on the merits, even though it "[might] not [have been] a 'strong' likelihood," to warrant preliminary injunctive relief. *See id.* at 471. The district court's analysis does not conflict with that in *Detroit Diesel.*

M & G also contends that, because the USW recently agreed that retirees must make medical contributions, Apple Grove retirees cannot possibly have a vested right to lifetime contribution-free health care. However, if benefits are vested, then subsequent concessions by the union cannot modify them without retirees' permission. *See Allied Chem. & Alkali Workers of Am., Local Union No. 1 v. Pittsburgh Plate Glass Co., Chem. Div.*, 404 U.S. 157, 181 n.20, 92 S. Ct. 383, 30 L. Ed. 2d 341 (1971).

Given the inapplicability of the capping agreements, the district court did not clearly err in finding that pre-August 9, 2005 retirees had a vested right to receive contribution-free health care benefits.

D.

Plaintiffs cross-appeal the scope of the permanent injunction. They contend that the district court abused its discretion when it ordered retirees and dependents previously enrolled in the pre-2007 Comprehensive Plan to be enrolled in the current Comprehensive Plan instead of being reinstated to the pre-2007 plan.

Plaintiffs argue that the district court misapplied *Reese v. CNH America.* In *Reese*, we held that retirees whose lifetime health care benefits had vested could nonetheless be subject to "reasonable changes" in their health care benefits, as long as the changes were "reasonable in light of changes in health care" and "roughly consistent with the kinds of benefits provided to current employees." 574 F.3d at 326 (citations omitted). However, this was only the case because the CBA did not contain any statements to the contrary. *See id.*

Plaintiffs argue that the P & I agreements specify the precise benefits provided to retirees. They cite, for example, the 2000 P & I stating that "[a]fter the date of the Employee's retirement, the deductible * * * shall be limited to $175 per person, $350 per family * * * * *" However, they do not explain why

these plan specifics, unlike those in *Reese*, are vested for life. Plaintiffs argue that vested no-cost medical coverage would be illusory if the Comprehensive Plan is "allowed to be whittled away under the guise of 'plan design changes' until no shred * * * remained," but that is a red herring because our reasonableness requirement does not permit such an extreme "whittling."

The 2007 changes to the Comprehensive Plan that Plaintiffs point to were not unreasonable. Plaintiffs cite increased prescription drug costs and annual deductibles that do not appear to be severe and unreasonable (e.g., co-pay for generic drugs going from $4 to $10, annual prescription drug deductible going from $175 to $250). The increase in the maximum out-of-pocket limit from $500 to $4,000 per family is the most significant change cited, but not so large that the district court clearly erred in finding it to be "reasonable in light of changes in health care." *Id.* at 326 (quotation marks omitted).

III.

For the above reasons, we affirm the judgment of the district court.

853 F. Supp. 2d 697

Hobert Freel TACKETT, et al., Plaintiffs,

v.

M & G POLYMERS USA, LLC, et al., Defendants.

Case No. 2:07-cv-126.

United States District Court,
S.D. Ohio,
Eastern Division.

Feb. 21, 2012.

David Marvin Cook, Claire W. Bushorn, Jennie Gayle Arnold, Cook Portune & Logothetis LLC, Cincinnati, OH, for Plaintiffs.

Mark A. Knueve, Thomas Howard Fusonie, Columbus, OH, Andrew Lylburn Scroggins, Deborah S. Davidson, John R. Richards, Morgan Lewis & Bockius, Philip A. Miscimarra, Chicago, IL, Christopher A. Weals, Simon J. Torres, Washington, DC, for Defendants.

OPINION AND ORDER

GREGORY L. FROST, District Judge.

This is a class action ERISA case involving the contractual right to lifetime contribution-free health care benefits for retirees who worked for M & G Polymers USA, LLC and its predecessors. The matter came on for a bench trial in May 2011 on the issue of liability. The Court found in favor of those plaintiffs in Subclasses One through Four and against Defendants, but in favor of Defendants and against those

plaintiffs in Subclass Five. The Subclass One through Four Plaintiffs then filed a motion for a permanent injunction, seeking the reinstatement of lifetime contribution-free health care benefits for the plaintiff retirees and their surviving spouses or dependents. (ECF No. 196.) For the reasons that follow, this Court **GRANTS** the motion.

I.

A. Background

The class (retirees, their spouses, and surviving spouses or other dependents of individuals who worked for the named defendant company) assert that although they have a right to lifetime retiree health care benefits, the company is requiring them to pay for those benefits in violation of various collective bargaining agreement ("CBA") provisions.[1]

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[1] The parties have agreed on the class and subclasses involved, which are as follows:

Class:

All retired employees of M & G Polymers USA, LLC ("M & G") and/or its predecessor company, the Shell Chemical Company ("Shell"), who worked at the Point Pleasant Polyester Plant ("Plant") in Apple Grove, West Virginia and were represented by the USW or its predecessor unions ("Union") in collective bargaining, and who retired or left service from the Plant having met the eligibility requirements for retiree health care benefits specified in the applicable collective bargaining agreements ("CBAs") and P & I Agreements, as well as the spouses and surviving spouses and other dependents of those retired former employees who also claim a right to such benefits, and

(Continued on following page)

the surviving spouses of Union-represented Plant employees who died while employed at the Plant who also claim a right to such benefits (the "Class").

Subclass 1: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P & I Agreement dated May 15, 1991, through May 15, 1994, as adopted by the CBA between Goodyear Tire & Rubber Company ("Goodyear") and the Union for the Plant effective November 6, 1991, through November 6, 1994, and as adopted by Shell, and their eligible surviving spouses and dependents.

Subclass 2: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P & I Agreement dated July 20, 1994, through July 20, 1997, as adopted by the CBA between Shell and the Union for the Plant effective November 6, 1994, through November 6, 1997, and their eligible spouses and dependents.

Subclass 3: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P & I Agreement dated May 9, 1997, through May 9, 2003, as adopted by the CBA between Shell and the Union for the Plant effective November 6, 1997, through November 6, 2000, and their eligible spouses and dependents.

Subclass 4: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P & I Agreement dated November 6, 2000, through November 6, 2003, as adopted by the CBA between M & G and the Union for the Plant effective November 6, 2000, through November 6, 2003 and applicable until August 8, 2005, and their eligible spouses and dependents.

(Continued on following page)

Plaintiffs Hobert Freel Tackett, Woodrow K. Pyles, and Harlan B. Conley are all Ohio residents and retirees from the Point Pleasant Polyester Plant in Apple Grove, West Virginia. They and similarly situated retirees belong to a labor union, Plaintiff United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC ("USW"), which represented (or at least one of its predecessor unions represented) them as employees of Defendant M & G Polymers USA, LLC ("M & G") (which bought the plant in 2000), or one of its predecessor companies, such as the Shell Chemical Company (which owned the plant from 1992 to 2000) and The Goodyear Tire & Rubber Company (which owned the plant until 1992). Plaintiffs' theory of the case is that the CBA provides vested retiree health care benefits as a result of the following language, which appears in various agreements:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension

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> *Subclass 5:* Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the CBA between M & G and the Union for the Plant effective August 9, 2005 through November 6, 2008 or any subsequent CBA between M & G and the Union for the Plant, and their eligible spouses and dependents.

(ECF No. 103, at 2-7.)

> Plan * * * whose full years of attained age and full years of attained continuous service * * * at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of [health-care] benefits * * * * Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health care] benefits * * * * Failure to pay the required medical contribution will result in cancellation of coverage.

In addition to a series of main agreements, a number of side letters are involved in this litigation. The Sixth Circuit previously explained these documents as follows, before remanding the action to this Court for additional factual development:

> A series of collective bargaining agreements has been in force at the Plant, with each typically lasting around three years before renegotiation. The first letter agreement, signed contemporaneously with the 1991-1994 collective bargaining agreement, was adopted "for purposes of conforming with the new Financial Accounting Standard Board (FASB) accounting requirement" that required accrual accounting of healthcare benefits. This new requirement hurt a company's balance sheet performance if the company

> had no cap on its health-care costs. While signed in 1991, the caps were not to take effect until July 1, 1997. Concurrent with the 1994-1997 collective bargaining agreement, another cap letter postponed the effective date of the caps to 2004.

Tackett v. M & G Polymers, USA, LLC, 561 F.3d 478, 483 n.1 (6th Cir. 2009).

Plaintiffs claim that on or about January 1, 2007, Defendant M & G acted contrary to the agreements by unilaterally modifying the health care benefits by shifting a large part of the health care costs onto the class members. The other named defendants are M & G-sponsored health plans through which the class members receive health care benefits: the M & G Comprehensive Medical Benefits Program for Employees and Their Dependents ("Comprehensive Plan"), the M & G Catastrophic Medical Plan, the M & G Medical Necessity Benefits Program of Hospital, Surgical, Medical, and Prescription Drug Benefits for Employees and Their Dependents ("Medical Necessity Plan"), and the M & G Major Medical Benefits Plan ("Major Medical Plan").

Plaintiffs filed the instant action on behalf of the named retirees and their surviving spouses or dependents, as well as other similarly situated retirees and their surviving spouses or dependents, on February 9, 2007. (ECF No. 1.) Via their amended complaint, Plaintiffs originally asserted three claims: violation of labor agreements, actionable under Section 301 of the Labor Management Relations Act

("LMRA"), 29 U.S.C. § 185(a) (Count I); violation of employee welfare benefit plan, actionable under Sections 502(a)(1)(B) and (a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3) (Count II); and breach of fiduciary duty under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (Count III). (ECF No. 14 ¶¶ 26-31.).

Defendants then filed a motion to dismiss the amended complaint (ECF No. 19), and this Court granted that motion (ECF No. 63). On appeal, the Sixth Circuit Court of Appeals affirmed the dismissal of the § 502(a)(3) claim constituting Count III, but reversed and remanded the remaining Count I § 301 claim and Count II §§ 502(a)(1)(B) and (a)(3) claim (ECF No. 68). Defendants unsuccessfully sought summary judgment on Counts I and II, and the matter progressed to a bench trial held from May 9, 2011, to May 16, 2011. This Court filed an August 5, 2011 Opinion and Order, 2011 WL 3438489, in which the Court found in favor of Plaintiffs in Subclasses One through Four and against Defendants on the issue of liability as described herein on Plaintiffs' Count I and II claims. (ECF No. 177.) The Court also found in favor of Defendants and against Plaintiffs in Subclass Five on those claims. This left for resolution the issue of damages, which the Court had previously bifurcated from the liability issue and upon which the parties are currently working. (ECF No. 207.)

Also in need of disposition is the remaining plaintiffs' pursuit of the reinstatement of their lifetime

contribution-free health care benefits. That issue is before the Court by way of Plaintiffs' motion for a permanent injunction (ECF No. 196), Defendants' memorandum in opposition (ECF No. 205), and Plaintiffs' reply memorandum (ECF No. 206). The motion came on for an in-court hearing on February 13, 2012, and the Court took the injunctive relief issue under advisement at the conclusion of that proceeding.

B. Agreed Facts

The Final Pretrial Order set forth the parties' agreed facts, providing:

> The following facts are established by admissions in the pleadings or by stipulation of counsel:
>
> 1. M & G Polymers USA, LLC ("M & G") is a producer of polymer and related chemical products with a facility located in Apple Grove, West Virginia ("the Apple Grove facility," also known as the "Point Pleasant Plant").
>
> 2. The Goodyear Tire & Rubber Company ("Goodyear") owned the Apple Grove facility until November 20, 1992, when Shell Chemical Company, an affiliate of Shell Oil Company ("Shell"), purchased it.
>
> 3. Production, laboratory, and maintenance employees at the Apple Grove facility are represented by the United Steel, Paper & Forestry, Rubber, Manufacturing, Energy, Allied

Industrial & Service Workers International Union, AFL-CIO ("USW") and its Local 644L.

4. Prior to 1995, production, laboratory, and maintenance employees at the Apple Grove facility were represented by the United Rubber Workers ("URW"). The URW merged with the USW in 1995.

5. Retiree Plaintiff Class Representatives H. Freel Tackett, Woodrow Pyles, and Harlan Conley (together with the Class members, the "Retiree Plaintiffs") were employed at the Apple Grove facility and were members of the collective bargaining unit represented by the Union.

6. Mr. Tackett retired on or about March 1, 1996. Mr. Pyles retired on or about January 1, 1996. Mr. Conley retired on or about August 1, 1998.

7. On November 6, 1991, Goodyear and Local 644 of the URW entered into a collective bargaining agreement ("CBA") effective November 6, 1991, to November 6, 1994.

8. On May 15, 1991, Goodyear and the URW and certain URW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective May 15, 1991, to May 15, 1994 ("1991 Master P & I Agreement").

9. The 1991 Master P & I Agreement between Goodyear and the URW and certain URW locals included a side letter, "Letter G,"

dated May 15, 1991, dealing with retiree medical benefits ("1991 Letter G").

10. Goodyear created a Summary Plan Description ("SPD") that described the employee benefit programs applicable to hourly rated employees at the Apple Grove facility as of May 15, 1991.

11. Goodyear and Shell entered into an agreement dated December 18, 1992, pertaining to the employment by Shell of certain employees of Goodyear at the Apple Grove Facility (the "Employee Agreement").

12. On December 29, 1993, Shell formally adopted those Goodyear benefit plans that were previously in effect at Apple Grove for represented employees at the Apple Grove facility.

13. On July 20, 1994, Goodyear and the URW and certain URW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective July 20, 1994, to July 20, 1997 ("1994 Master P & I Agreement").

14. The 1994 Master P & I Agreement between Goodyear and the URW and certain URW locals contained a side letter, Letter G, dated July 20, 1994 ("1994 Letter G") dealing with retiree medical benefits.

15. On November 6, 1994, Shell and Local 644 of the URW entered into a CBA effective November 6, 1994, to November 6, 1997.

16. On May 9, 1997, Goodyear and the USW and certain USW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective May 9, 1997, to May 9, 2003 ("1997 Goodyear Master P & I Agreement").

17. The 1997 Goodyear Master P & I Agreement between Goodyear and the USW and certain USW locals included a side letter, Letter H, dated May 9, 1997, dealing with retiree medical benefits ("1997 Letter H").

18. On November 6, 1997, Shell and the USW and Local Union 644 entered into a CBA effective November 6, 1997, to November 6, 2000 ("1997 CBA").

19. M & G purchased the Apple Grove facility from Shell effective June 1, 2000.

20. In connection with the purchase, M & G and Shell entered into a 7 Human Resources Agreement dated June 1, 2000 ("HR Agreement").

21. In September 2000, M & G and the USW on behalf of Local 644L began bargaining for a potential extension of the 1997 CBA, which by its terms expired on November 6, 2000, and subsequently engaged in bargaining for a successor to the 1997 CBA.

22. On November 6, 2000, M & G and the USW and Local Union 644L entered into a CBA effective November 6, 2000, through November 6, 2003 ("2000-2003 CBA").

> 23. In September 2003, M & G and the USW on behalf of Local 644L commenced bargaining for a successor to the 2000-2003 CBA which was due to expire November 6, 2003. This bargaining encompassed more than 60 days of negotiations from September 2003 through August 2005 (the "2003-2005 Bargaining").
>
> 24. On August 9, 2005, M & G and the USW on behalf of Local Union 644L reached agreement on a new CBA effective August 9, 2005, to November 5, 2008 ("2005 CBA").
>
> 25. The 2005 CBA included LOU 2003-6, dealing with retiree medical benefits, which was signed by Union chief spokesperson Karen Shipley and Company representative Kimm A. Korber.

(ECF No. 165, at 4-6.)

C. May 2011 Trial Testimony

In addition to introducing testimony via deposition transcripts, the parties presented live trial testimony by select witnesses. The Court briefly summarizes the key points of each such witness' testimony below. For ease of reference, much of the following content is taken verbatim from this Court's August 5, 2011 Opinion and Order, a decision that the Court incorporates fully herein by reference. (ECF No. 177.)

1. Woodrow Pyles

Retiree Woodrow Pyles was the first witness to testify. Pyles testified that he had begun working at the Apple Grove facility on May 1, 1959. In December 1992, Shell bought the plant from Goodyear, which Shell later sold to M & G. He retired on January 1, 1996. A union member, Pyles testified that he held a number of positions in the union, including that of union steward and that of liaison. He stated that he would attend P & I conferences and would study the P & I booklet. After a new pension and insurance agreement ("P & I agreement") had been reached, Pyles testified, the union would hold a conference to explain the changes. He also testified that the local CBA governs working conditions and would be negotiated locally by the union.

Notably, Pyles testified several times that it is the local's position and unwritten policy that letters that are not printed in the booklet distributed to the local union members do not apply to the local union. He stated that no cap letters applied to the Apple Grove agreements. Although he had obtained a copy of Letter G at a conference regarding the 1991 agreement, Pyles testified, he did not distribute the letter to the local members because it was not part of the booklet. Pyles explained that the summary plan description described the plan as non-contributory, with the company paying the entire cost of the plan. He testified that he has not paid union dues since his retirement and that he never gave the union permission to represent him now. Pyles also testified how he

has paid the premium for himself and his spouse since its implementation, which he protested in a series of letters to M & G's Kimm Korber that he discussed.

2. Hobert Freel Tackett

Retiree Hobert Freel Tackett testified that he began working at the Apple Grove facility on February 7, 1966, and retired from that facility on March 1, 1996. He stated that he had held a number of local union positions, including president and vice-president, and was a member of the local bargaining unit. Similar to Pyles, Tackett identified various agreements and testified that the CBA covers working conditions while the P & I agreement governs benefits. He testified that he was never aware of any employer contribution limit or cap under the agreement and that he first saw a cap letter only after this litigation had commenced. Tackett testified that he understood the applicable plans to provide retirees who had 95 points with contribution-free medical care for life; they had to pay only if they had less than 95 points. He also testified that he did not believe that letters not printed in the booklet controlled retiree benefits. Tackett stated that he relied on the booklet for medical and pension benefits information. Similar to Pyles, Tackett testified that he had never granted anyone the right to bargain on his behalf since retired.

3. Ron Hoover

Ron Hoover testified next on behalf of Plaintiffs. Hoover explained that prior to his retirement—he is now a union consultant—he worked for the international union with the primary responsibility of working with the master bargaining agreement. He explained that a master bargaining agreement would be negotiated typically every three years, and after that agreement was secured, another agreement would be negotiated in an approach termed "pattern bargaining." Locals would ratify the master agreement and then would negotiate supplemental agreements focused on their specific issues. Not all locals were part of the Goodyear master bargaining, Hoover testified, and Local 644 was not. Some locals not under the master agreement had "me too" agreements in which their own CBA language incorporated some or all of the master agreement provisions. Hoover testified that he believed that the Apple Grove plant stood on its own.

Hoover stated that he was never the lead spokesman at the Apple Grove plant, that the plant was not part of the master agreement, that he was not certain how they even got the pattern agreement, and that he did not know for certain whether Apple Grove adopted the P & I insurance agreement. He also testified that he had never negotiated Local 644 agreements with Shell or M & G. He indicated that he had attended bargaining sessions where benefits had been discussed.

Hoover explained the 1991 cap letter as a union compromise to help Goodyear control or minimize its liabilities; he explained that the letter was a way to avoid showing the extent of projected liability for retiree medical benefits due to FASB considerations. In other words, Hoover explained, the cap letter was a mechanism by which a company could minimize numbers to attract investors. He explained how the letter worked and the importance of what he called the "bite date," or the date on which retirees would have to actually begin contributions toward their medical insurance. Hoover emphasized the importance of always moving the bite date out so that it could always be subject to further movement by negotiation.

According to Hoover, he has no knowledge that the Letter G cap letter was ever adopted at the Apple Grove plant. He explained that the letter was not part of the 1994 agreement between Shell and Local 644. Although he may have participated in 1997 negotiations, Hoover testified, his role was to explain how the Goodyear master agreement worked. Hoover stated that he lacked the authority to bind Local 644 to anything and that only the head negotiator had such authority. He testified that he did not know whether the cap letter labeled as Letter H automatically applied to M & G. Thus, Hoover testified, when he spoke with Randy Moore, he told Moore that if the cap letter applied, Moore should be certain to move the bite date out so that it did not impact retirees. Hoover also testified that he told Karen Shipley the

same thing in 2003. Hoover disagreed with the contention that there was a link between the 95-point rule and the cap letter.

Hoover stated on cross-examination that by agreement not all letters were printed in the booklets. As an example, he explained that the 1991 Letter G was part of the master agreement even though it was not in the printed booklet. Hoover stated that a general understanding existed between the union and company representatives that the bite date would always be moved. He stated that the union never intended to have retirees pay a premium and that he understood that the company representatives could not say publicly that there would never be retiree contributions because the accountants would then not certify the FASB statements.

Hoover explained that the Apple Grove plant appeared to be some sort of "me too." He stated that he could not identify well a marked-up copy of the 2000 agreement, and Hoover indicated that he could not say for a fact whether cap letters were part of the adopted agreement. Such letters were not printed in booklets, Hoover again explained. He testified that if the letter information was not presented to the local members, then the local representatives were not doing their jobs. Hoover also testified that a "me too" local could adopt the P & I agreement but not letters and again stated that he did not know what Local 644 had done. He stated that he did not know whether the letters were ever presented to the local members. Hoover did state that if the cap letters were not

renewed, then they were gone. Hoover testified that he had been careful to never interpret the Apple Grove agreement for Local 644.

4. Randall Moore

Randall Moore is currently the Sub-District Director of the international union and was previously a staff representative. He was assigned to Apple Grove negotiations in late summer 2000. Moore testified that he relied on the local committee in these negotiations and explained that after he was unsuccessful at negotiating a two-year extension of the existing agreement, negotiations for a new P & I agreement continued.

Moore testified that based on his experience, the issue of retiree benefits is typically a subject of forward-looking negotiations in which future retirees' benefits are discussed, but existing retiree benefits remain fixed. He stated several times that it was his understanding that Local 644 is a "me too" that accepted only parts of the "Big Rubber" master agreement. Moore stated that, to his knowledge, Shell was not a part of the "Big Rubber" negotiations.

He also testified that the 1997 P & I agreement for the Apple Grove plant did not reference Letter H. Moore stated that when local individuals such as Sam Stewart brought the cap letter to Moore's attention, Moore spoke to Hoover. Hoover provided Moore with a copy of Letter H because the local committee did not have a copy, Moore testified, and Hoover explained

that the cap letter is a FASB accounting letter. Moore testified that Hoover never told him that Letter H applied and only suggested that Moore push back the contribution date if the letter were applicable to Apple Grove. Moore also testified that he looked for and never found any document indicating that Letter H applied.

Moore stated that it was less than clear whether the cap letter applied. He testified that the local committee proposed pushing the effective contribution date out, but that the company denied the proposal. The company was also bewildered by Letter H, Moore explained, and on October 17, 2000, the company's chief negotiator, David Dick, responded to Moore's request for written clarification by providing a document stating the company's position that Letter H did not apply.

Moore also testified that the Apple Grove booklet needed cleaned up [sic] because it contained provisions that did not apply to the local plant. He explained that the parties agreed to remove these provisions while abiding by the agreement they had reached. Thus, Moore testified, Letter H was removed, and the 2000 P & I agreement that resulted does not contain Letter H.

He stated that for a period of time, Karen Shipley had been assigned to Local 644 until he was reassigned back to the local. Shipley had asked Moore about Letter H during the subsequent negotiations between the local and M & G, he testified, and Moore

explained that Letter H did not apply. Moore testified that he was confused when presented with Letter of Understanding 2003-6 because the union had not agreed to its contents or that Letter H applied. M & G's new chief negotiator, Robert Long, was given a copy of Dick's October 2000 disavowal of the cap letter's application, Moore testified, but this did not change M & G's position. Moore testified that he stated to M & G in negotiations that he lacked the authority to bargain away benefits for existing retirees.

Moore testified that negotiations over Letter of Understanding 2003-6 went nowhere. He enlisted the aid of the international union's attorney, but the result was still the same. Moore testified that the union saw the handwriting on the wall as to what M & G was going to do, and that when Shipley signed Letter of Understanding 2003-6 on August 9, 2005, it was a simple formality because her name was already on the company-provided signature line. Moore explained that the union knew that future retirees would be covered differently than existing retirees. Although the union contested the lawfulness of M & G's actions, Moore stated, the company went ahead and implemented retiree contributions.

5. Karen Shipley

Karen Shipley is a staff representative for the international. She testified that she was part of the 2003 Apple Grove negotiations and acted as the

union's chief negotiator. She therefore had the authority to bind the union, she explained, and that the local committee assists the chief negotiator. After M & G's Long and Korber approached her with Letter H, Shipley spoke with Hoover. The parties disagreed over whether the letter applied, she explained, and she states that she informed the company that the union could not bargain over existing retiree benefits, which was a permissive subject of bargaining. The union disagreed that Letter H applied, Shipley testified, and took the position that given the company's disagreement, the letter should then be deleted.

Shipley testified that after offering to withdraw Letter of Understanding 2003-6, M & G reversed course and refused such withdrawal. M & G then implemented its last, best, and final offer, she testified, which included Letter of Understanding 2003-6. Shipley testified that the union never agreed to Letter of Understanding 2003-6 while she was negotiating.

6. Brian Wedge

Brian Wedge is currently on leave from the Apple Grove plant while he serves as a staff representative for the international. He testified as to his involvement in numerous Local 644 negotiations in numerous union positions. Throughout the ratification of these agreements, Wedge explained, no cap letters had ever been presented as part of the agreements to be ratified by local members. He discussed the 1997 agreement negotiations specifically and testified that

M & G had taken the position that it had separated from the master agreement. M & G's Dick stated that Shell had separated from the master agreement, Wedge testified, because Shell did not belong to the larger negotiating group responsible for that agreement.

In preparing for the 2000 negotiations, Wedge explained, he had heard of Letter H. Because he did not know whether the letter applied or what it was, Wedge testified, he spoke with Hoover and obtained a copy of the letter. Wedge testified that Letter H was not part of the agreement with which they had started. Since the time he began working at the Apple Grove plant in 1987, Wedge testified, such a cap letter had never been included in the booklets local members received.

Wedge testified that M & G took the position that the cap letter did not apply to M & G or Shell. He also testified that the union regarded the October 2000 Dick document as conclusive. The parties proceeded to adopt the 1997 booklet with some changes, Wedge explained, and produced the actual P & I agreement at a later date. Wedge testified that the parties knew they would have to remove content from the booklet that did not apply to Apple Grove. He stated that this was why he had made a handwritten notation on a union copy of Letter H indicating that the letter was to be removed. Wedge testified that the final copy of the P & I agreement distributed to union members did not contain Letter H.

When he was next part of the negotiating team in 2005, Wedge testified, the cap letter issue arose in conjunction with Letter of Understanding 2003-6. He indicated that Moore had questioned the applicability of a cap letter, and Wedge testified that no retirees had agreed that the union could negotiate benefits on their behalf. Wedge testified that the union attorney had informed the negotiators that the union had no right to bargain for the existing retirees. He repeated that the union was not legally permitted to bargain on behalf of the retirees. Wedge testified that the company nonetheless implemented its plan and that retirees have suffered as a result. Some people, he explained, won't speak to him as a result.

On cross-examination, Wedge testified that the union proposed in 2000 negotiations to move the cap letter effective date of retiree contributions because there was uncertainty over whether the letter applied. He stated that the Dick letter on behalf of M & G resolved the issue and that by the end of negotiations, it was settled that Letter H did not apply.

Wedge also explained the inapplicability of the master agreement. He provided the example of when Moore asserted during negotiations that the master agreement's pension multipliers automatically applied and M & G responded by adopting the position that the master agreement did not control. Wedge also testified that the union was responsible for distributing for local ratification the agreement information. He indicated that there was never an agreement

between the company and the union as to what would go into the booklet.

7. Kimm Korber

Defendants' first witness was Kimm Korber, M & G's Human Resources Director. Korber testified that he had been hired in 2001 as Human Resources Manager for the Apple Grove plant and that his duties had included general human resources work as well as labor responsibilities. He stated that he had first become aware of issues with the P & I Agreement in the 2000 negotiations. Korber testified that because the Letter H effective date for contributions was after the next negotiations, he assessed that the letter would be discussed in the 2003 negotiations.

During those negotiations, Korber testified, Shipley had told him that the retiree benefits was a permissive subject of bargaining, that the parties could not reach an impasse over this issue, and that she was not interested in discussing the issue. He indicated that Shipley had proposed deleting Letter H. He also summarized the history of negotiations, stating that the union changed its position after it learned of Dick's October 2000 document.

Korber testified that he was not trained in benefits administration and that he has only a basic understanding of ERISA requirements. He stated that M & G is the plan sponsor and the named fiduciary and that the plan had never sent an ERISA notice

to retirees of their being subject to the cap or of the possible termination of benefits.

Korber also testified regarding meeting with Rex Rousch. He denied that Rousch told him that Letter H was a Goodyear document and not a Shell document, but stated that he obtained the letter from Rousch. When presented with various exhibits, Korber indicated that Letter H had not been part of local booklets and could not point to where the 2000 CBA or P & I agreements adopted the Goodyear Letter H.

When questioned regarding the October 2000 Dick response that disavowed cap letter application, Korber testified that he had not discussed the document with Dick. Korber stated that a chief negotiator has the authority to bind a company. When asked whether the union could rely on Dick's response, Korber essentially avoided the question and responded by discussing proposals.

Korber reviewed exhibits related to M & G's acquisition of the Apple Grove facility from Shell and various emails regarding Letter H. He denied that it was left to counsel to determine the effective date of Letter H, but confirmed that he was part of the decision to apply a cap to all retirees. Korber stated that this was not an actuary decision. He disagreed with the position of Moore and Shipley that they did not have the authority to bargain for retirees, but stated that without Letter H, bargaining for retirees would be a permissive subject of bargaining.

Korber also testified regarding M & G's due diligence in the plant purchase. He further stated that he was aware of Letter H in 2001, although he did not mention the application of caps in a strategy memorandum he wrote on M & G's benefits program. This failure to mention Letter H continued throughout other documents and communications Korber sent involving benefits. In a July 12, 2004 email from Korber to Duane Lee, Korber testified, he did address Letter H, but he denied that this was the first time he sent Lee the letter. Korber testified regarding subsequent emails that noted that Letter H may not be deemed enforceable to Apple Grove and that discussed the possible impact of Letter H. He acknowledged his December 2005 email to Lee that concerned the topic of how much M & G would save if Letter H were applied to all retirees. Korber also acknowledged subsequent emails that tracked the effect of the cap letters, which was that retirees were being dropped from the benefits plan. In subsequent testimony, Korber did not disagree that over half of all retirees had died or been dropped from the benefits plan. In another email that Korber acknowledged, he stated that most retirees look to the booklet for a guide to retirement health plans.

8. Robert Long

The final witness to testify was attorney Robert Long. He explained that he routinely represents management in labor negotiations and that he has participated in between 200 and 300 negotiations.

One such negotiation was the Apple Grove bargaining that began in the fall of 2003. He testified that during these negotiations, Shipley stated that the union was not willing to discuss retiree medical benefits and that it was a permissive subject of bargaining. Long testified that generally speaking, retiree bargaining is a permissive, or non-mandatory, subject of bargaining and that a company and union can by mutual agreement enter into agreements on this topic. He later stated that the parties cannot modify vested benefits, but can modify non-vested benefits.

Long testified that following two union caucuses, the union returned to the table and mentioned Letter H, a cap letter, and that Sam Stewart had indicated that it was part of the binding agreement. He stated that no union representative suggested that Letter of Understanding 2003-6 applied only to future retirees. Long testified as to the circumstances surrounding his negotiation offer that, if the union took the position that Letter of Understanding 2003-6 implicated a permissive subject, then the company would withdraw it from the last, best, final offer. He testified that the company ultimately rejected the union's proposal to delete Letter H.

Long also testified that he never did any research as to whether Letter C or Letter H applied, but instead simply accepted the propositions that Shell had adopted Goodyear letters and that M & G had assumed Shell's contractual obligations. He had been told that M & G had a P & I book with Letters C and H in it. Long testified that he may have seen the

Dick response disavowing cap letter applicability, but he stated that he could not recall when. He testified that he relied upon Korber to be the primary architect for P & I proposals and stated that he had never read the 2000 P & I agreement cover to cover and that he did not know whether Letter H was part of that agreement. In subsequent testimony, Long stated that Stewart did not have the authority to bind the union, as opposed to Shipley, who held such authority.

D. February 2012 Hearing

In lieu of presenting additional testimony, the parties elected to proceed at the February 14, 2012 hearing on their previously filed briefs and accompanying declarations, with counsel making oral argument.

II.

A. Standard Involved

In considering whether entry of a permanent injunction is warranted, this Court must consider (1) whether Plaintiffs have succeeded on the merits of the case, (2) whether Plaintiffs will suffer irreparable injury in the absence of equitable relief, (3) whether the balance of hardships to the respective parties favors injunctive relief, and (4) whether entry of injunctive relief is in the public interest. *Duer Constr. Co., Inc. v. Tri-County Bldg. Trades Health Fund*, 132 F. App'x 39, 45 (6th Cir. 2005) (citing *PGBA, LLC v. United States*, 389 F.3d 1219, 1229 (Fed. Cir. 2004)).

See also eBay, Inc. v. MercExchange, L.L.C., 547 U.S. 388, 391, 126 S. Ct. 1837, 164 L. Ed. 2d 641 (2006) (setting forth similar test for permanent injunction); *Amoco Production Co. v. Village of Gambell, AK*, 480 U.S. 531, 546 n.12, 107 S. Ct. 1396, 94 L. Ed. 2d 542 (1987) ("The standard for a preliminary injunction is essentially the same as for a permanent injunction with the exception that the plaintiff must show a likelihood of success on the merits rather than actual success.").

B. Discussion

The central issue in this litigation has been whether Plaintiffs—the qualifying retirees, their spouses, and their dependants—have a vested right to lifetime, uncapped (or contribution-free) medical benefits. It is settled that those plaintiffs in the first four subclasses do. The extant issues are now what that right encompasses and whether Plaintiffs are entitled to an injunction ordering the implementation of that right at this juncture.

Plaintiffs are entitled to a permanent injunction. They have prevailed on the merits of their claims, with only the issue of damages remaining. The absence of an injunction now would essentially transform the liability determination into a Pyrrhic victory, at least in the short term. This would be an unacceptable result, especially in light of the consequent irreparable harm.

Lack of a permanent injunction at this point would continue to inflict irreparable injuries on Plaintiffs. Money will of course remedy some of the damages Plaintiffs have incurred. In the absence of equitable relief, however, Plaintiffs will suffer irreparable injury regardless of any money ultimately awarded. The submitted declarations detail various anecdotal evidence of the type of injuries that many if not most of the plaintiffs have incurred and will continue to incur. It is not an illogical leap to extrapolate from such anecdotal evidence recognition of the harm facing the greater class. Money simply cannot remedy many of these injuries, such as the ongoing quality of life concerns. The apparent potentially shortened life spans or lives of lesser quality marked by ongoing anxiety and undue strife are clear. Moreover, the balance of hardships to the respective parties favors entry of the injunction, with Plaintiffs suffering far greater hardship should this Court further delay reinstatement to coverage for those dropped from the plans and forestall stopping Defendants from collecting the improper 2012 premium that M & G indicates it will continue to impose. (ECF No. 206-3.)

The enforcement of contractual obligations and the judgment of this Court are also unquestionably in the public interest. Plaintiffs have presented this Court with numerous cases in the briefing supporting this point. Additionally, as Plaintiffs argue, it is in the public interest to transfer the burden of coverage to the private company that included such coverage

in its bargaining and not to keep much of the burden of providing health care coverage on the public by forcing numerous retirees and their dependants to rely upon public assistance programs.

Defendants devote much time to arguing minor points to the contrary on these factors, but much of the arguments presented are simply red herrings that warrant little discussion. For example, waiting for a conclusive damages determination before stopping premium collection and before reinstating those dropped from coverage would wholly fail to alleviate the irreparable harm many plaintiffs would incur. Such an approach would contravene logic by conflating measurable damages—out of pockets expenses—with intangible damages, such as the quality of life issues addressed above.

Contrary to Defendants' arguments, the fact that this litigation has been ongoing for five years does not weigh against a stay. Five years of impropriety on the part of M & G does not mean that a few more months or even years does not matter. Five years of unnecessary ongoing medical issues and financial hardship that cannot fully be undone matter. Defendants may characterize their opposition to the permanent injunction motion as seeking to maintain the status quo, but the status quo here is a company wrongfully denying individuals critical benefits to which the individuals are lawfully entitled.

Equally unpersuasive is Defendants' dubious paternalistic concern for the retirees. Defendants

argue that should they prevail on appeal, many of the retirees may end up without health care coverage. Because it is M & G's actions that have already divested numerous retirees of such benefits, the Court is skeptical of the depth of Defendants' concern. In any event, such an issue is of little weight in the injunction inquiry. Any loss of coverage that might result should the Court enter a permanent injunction now and Defendants then subsequently prevail on appeal does not weigh against entering the relief requested. As the Court has previously noted, it doubts that Defendants will prevail on appeal. More important for today's issue is that any loss of coverage that would result if the Court is wrong would be Plaintiffs' own fault. They has [sic] asked for the Court to place them on such a possible path, and even if unlikely to be realized, the path Plaintiffs request presents a possible self-inflicted wound. In other words, because Plaintiffs are rolling the dice even if they do not see themselves as necessarily gambling, Defendants should not benefit from protecting Plaintiffs from hypothetical harm to which Plaintiffs ask to expose themselves.

This Court therefore rejects Defendants' arguments, which again and again return to the underlying premise that delay is fine because money can function as an overarching salve. This oversimplification ignores the realities involved here.

Defendants then argue that, in the event that the Court elects to enter a permanent injunction, this Court should require a bond. Both sides direct this

Court to cases involving bonds related to Federal Rule of Civil Procedure 65, and these cases recognize the well-settled proposition that whether to require a bond is within the discretion of the Court. *Moltan Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995). The circumstances of this case weigh against imposition of such a requirement. The age of Plaintiffs and their financial means outweighs the notably limited possibility that Defendants will prevail on appeal. Defendants in turn have prospered from their impropriety for years and have presented testimony to this Court in support of their liability arguments that the Court recognized as simply false. Plaintiffs have prevailed on the merits and have generally suffered financial hardships while pursuing what lawfully belongs to them. Defendants have enjoyed a financial windfall for years as a result of their improper conduct, even if the subsequent damages portion of this action will serve to divest Defendants of a portion of that ill-gotten gain. Requiring any bond, much less one of the sort contemplated by Defendants, would only work to further effectuate another injustice on Plaintiffs. This Court in its discretion declines to require a bond.

Having made the threshold determinations that entry of a permanent injunction is warranted and that no bond would be appropriate, this Court turns to the issue of the proper scope of that injunction. This raises the core issue of what precisely vested.

Plaintiffs argue that the right to the health care plans as they existed pre-2007 is what vested. They

suggest that this Court has already recognized that fact, and, failing that, urge the Court to accept that such vesting occurred. Defendants of course disagree and argue that at best, only the right to health care vested without such specific plan details having vested. Thus, Defendants argue, any reinstatement to health care benefits should be only to the plans as they exist now.

Contrary to Plaintiffs' contention, this Court did not previously hold that the prior plan details vested. To explain this point, it is necessary to review the Court's prior vesting discussions, however repetitious that review may be. As in the summary of the facts above, much of the following is often taken verbatim from this Court's incorporated August 5, 2011 Opinion and Order. (ECF No. 177.) That decision answered whether contribution-free benefits vested. Today's decision answers whether specific plans or plan details were within the scope of what vested.

The Sixth Circuit has held that "[r]etiree health benefit plans * * * are welfare benefit plans; thus, vesting only occurs if the parties so intended when they executed the applicable labor agreements." *Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008). *See also Tackett*, 561 F.3d at 489. The presence or absence of such intent is again critical here because, as the court of appeals has explained, "[i]f the parties do not intend to vest the benefits, the former employer can modify the retiree benefits without breaching a collective bargaining agreement." *Tackett*, 561 F.3d at 489. The appellate court has also explained that

"[a] court may find vested rights 'under a CBA even if the intent to vest has not been explicitly set out in the agreement.'" *Id.* (quoting *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 915 (6th Cir. 2000)).

The Sixth Circuit has described the "broad analytical framework" that this Court must apply to the vesting issue as follows:

> The seminal case for determining whether the parties to a CBA intended benefits to vest is *UAW v. Yard-Man*, 716 F.2d 1476, 1479 (6th Cir. 1983). Under *Yard-Man*, basic rules of contract interpretation apply, meaning that courts must first examine the CBA language for clear manifestations of an intent to vest. *Id.* Furthermore, each provision of the CBA is to be construed consistently with the entire CBA and "the relative positions and purposes of the parties." *Id.* The terms of the CBA should be interpreted so as to avoid illusory promises and superfluous provisions. *Id.* at 1480. Our decision in *Yard-Man* also explained that "retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference * * * that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." *Id.* at 1482. With regard to the "*Yard-Man* inference," later decisions of this court have clarified that *Yard-Man* does not create a legal presumption that retiree benefits are interminable. *Yolton*, 435 F.3d at 579. Rather, *Yard-Man* is properly understood as creating an inference only if the

> context and other available evidence indicate an intent to vest. *Id.*
>
> When an ambiguity exists in the provisions of the CBA, then resort to extrinsic evidence may be had to ascertain whether the parties intended for the benefits to vest. *Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am. v. BVR Liquidating, Inc.*, 190 F.3d 768, 774 (6th Cir. 1999). If an examination of the available extrinsic evidence fails to conclusively resolve the issue and a question of intent remains, then summary judgment is improper. *Int'l Union, United Mine Workers of Am. v. Apogee Coal Co.*, 330 F.3d 740, 744 (6th Cir. 2003).

Noe, 520 F.3d at 552. The court of appeals has further clarified:

> Courts reviewing a collective bargaining agreement must also keep in mind the context of labor-management negotiations on retiree health-care benefits: "because retirement health care benefits are not mandatory or required to be included in an agreement, and because they are 'typically understood as a form of delayed compensation or reward for past services' it is unlikely that they would be 'left to the contingencies of future negotiations.'" *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 580 (6th Cir. 2006) (quoting *Yard-Man*, 716 F.2d at 1481-82).

Tackett, 561 F.3d at 489. Application of these directions to this case led this Court to the conclusion that Plaintiffs obtained vested medical benefits.

That conclusion does not conflict with the Sixth Circuit's prior discussion of the issue of vesting. Citing the November 6, 2000 CBA language set forth above, the court of appeals previously made several critical points:

> First, the "full Company contribution" language suggests that the parties intended the employer to cover the full cost of health-care benefits for those employees meeting the age and term-of-service requirements. Keeping in mind the context of the labor-management negotiations identified in *Yard-Man*, we find it unlikely that Plaintiff USW would agree to language that ensures its members a "full Company contribution," if the company could unilaterally change the level of contribution. The CBA has no limitation on the amount of a company contribution and if the Defendants' argument were accepted, the company presumably could lower the contribution to zero without violating this language. Such a promise would be illusory.
>
> Second, the limiting language, "[e]mployees will be required to pay the balance of the health care contribution," follows the provision requiring contributions by those retirees who had not attained the requisite seniority points. From the placement of this language, we can reasonably infer that it did not apply to all retirees, but only to those

> retirees who had not attained the requisite seniority points.
>
> Third, the collective bargaining agreement tied eligibility for health-care benefits to pension benefits. This is another factor indicating that the parties intended the health care benefits to vest upon retirement.

Tackett, 561 F.3d at 490. This Court previously noted that, on its face, the court of appeals' language appears to present a controlling interpretation of the CBA that proves dispositive of at least the vesting issue, if not the issue of capped versus uncapped benefits.

This Court recognized, however, that the next sentence of the court of appeals' opinion suggests that perhaps the Sixth Circuit was not handing down an opinion that proves dispositive outside the Rule 12 context. Following the third point, the *Tackett* panel stated that "[w]e hold that the Plaintiffs' Complaint presented a plausible claim that the parties intended to vest health-care benefits. Accordingly, we hold that the district court erred in granting the Defendants' Rule 12(b)(6) motion on the § 301 claim." *Id.* This language might cast the otherwise essentially conclusory language of the three points (noting that the appeals court did use some qualified language such as "suggests") into a qualified light and presents the issue of whether the Sixth Circuit was interpreting the language as a matter of law or simply saying that it presented a plausible claim for Rule 12(b)(6) purposes and that the vesting issue was left open upon remand.

The Court continues to find the answer to the vesting issue in the next portion of the appellate decision. There, the *Tackett* panel moved from Count I, the § 301 claim, to Count II, the § 502(a)(1)(B) claim. After outlining the considerations relevant to deciding the vesting issue, the Sixth Circuit stated that "[t]he determination above that *the parties intended health-care benefits to vest* carries over to the ERISA § 502(a)(1)(B) claim. The Plaintiffs have therefore presented a plausible claim under ERISA § 501(a)(1)(B)." *Tackett*, 561 F.3d at 490 (emphasis added). Notably, the court of appeals phrased its summary of its prior discussion as an unqualified declaration—"the parties intended health-care benefits to vest"—without linking that summary statement to a mere finding of a plausible claim. By presenting the intended vesting as a fact leading to the result that Plaintiffs had presented a plausible claim, the appellate court pointedly issued a conclusion instead of merely recognizing a credible possibility.

In other words, had the Sixth Circuit said that based on the factual allegations that it must accept as true, it concludes that Plaintiffs have stated a plausible claim for Rule 12(b)(6) purposes, this Court would perhaps consider the vesting issue open on remand. But what the court of appeals did was conclude that the parties intended vesting, which meant that Plaintiffs had of course stated a plausible claim, which meant that they should have survived the Rule 12(b)(6) attack. The distinction is important; it is the difference between saying that the facts *likely* present

a viable claim and saying that the facts *do* present a viable claim. This Court therefore stands by its prior conclusion that the Sixth Circuit answered the threshold vesting issue.

As noted in the bench trial decision, however, even if this Court is incorrect in its interpretation of the appellate precedent and the court of appeals did not intend to be dispositive on the issue and reasonably only intended to reach the issue of plausibility of the claim presented, the Court recognizes that there are no facts that would defeat the same conclusions. The linking of eligibility for health care benefits to pension benefits indicates the parties' intent that health care benefits vested upon retirement. *See Reese v. CNH America LLC*, 574 F.3d 315, 322 (6th Cir. 2009) (noting cases in which the tying of eligibility for pension benefits to eligibility for health-care benefits "played a 'key' role in a vesting-of-health-benefits determination"). Regardless of the analytic path, the end result is still the same because, in light of the meaning of the CBA language, this Court must conclude that vesting occurred. Whether the appellate path or this Court's own analysis leads to this conclusion is ultimately irrelevant.

As also noted, however, *what is significant is that the Sixth Circuit did not conclusively state the precise nature of the right to health care benefits that vested* in light of the fact that the appellate panel left the door open for further related factual development and analysis on remand. After summarizing the cap letters and the postponement of the effective date of

the caps, the Sixth Circuit stated that "[t]he import of this perpetual postponement and the applicability of these cap letters to the current parties are fact issues that must be resolved by the district court outside of the Rule 12(b)(1) determination." *Tackett*, 561 F.3d at 482 n.1. Thus, as in *Reese*, the core issue in this case is ultimately not "did the benefits 'vest,'" but rather "what does vesting mean in this context." *Reese*, 574 F.3d at 321. The bench trial answered *what* vested—the right to lifetime contribution-free health care benefits—and today the Court is called upon to explain whether what vested includes specific benefits.

What vested for those plaintiffs in Subclasses One through Four was a right to contribution-free lifetime health benefits. What vested for those plaintiffs in Subclass Five was a right to capped lifetime health benefits, contingent on the qualifying plaintiffs paying the above-cap premiums. The Court has not previously explained whether these rights encompass a right to the particular benefits in place at the point of retirement. This Court concludes that they do not, which means that those plaintiffs in Subclasses One through Four should be reinstated into the current versions of the health care plans involved.

While disagreeing with the Court's vesting analysis, Defendants have taken the position that the health care benefits agreements condition exercise of any vested right to benefits on satisfaction of the cost-sharing precondition. Defendants' theory of the case is that there has been continuity in the wholesale assumption of contractual obligations by each owner

of the Apple Grove plant, an unbroken line of side agreements that provide contextual meaning to the language of the main agreements. They posit that the side agreements apply to the plant and its retirees either expressly or under a "me too" arrangement. Thus, Defendants reason, the right to the contingent benefits is clear provided a retiree satisfies the condition of making his or her contribution. This is a permissible scheme; a plan may contemplate fully funded, lifetime health care benefits *or* defined-contribution health care benefits. *Wood v. Detroit Diesel Corp.*, 607 F.3d 427, 432 (6th Cir. 2010). The scheme Defendants assert is not, however, the scheme that exists here.

The factual history that the parties present could not be more different. On one side, Defendants have presented largely dubious testimony to support the theory that an unbroken chain of cap letters informs agreements resulting in at most lifetime health care benefits that are contingent on satisfaction of a cost-sharing arrangement. On the other side, Plaintiffs have presented notably more compelling evidence that Defendants have engaged in after-the-fact company scrambling to find a way to impose unilaterally application of cap letters as a cost-savings measure that defies the agreements the caps puncture.

This Court untangled which agreements do in fact apply to the Apple Grove plant and concluded that Defendants have conflated companies and agreements. The pre-August 5, 2005 side agreements to the master agreements do not apply to Apple Grove.

Rather, the intent and effect of the applicable operative documents governing Subclasses One through Four present a lifetime benefits scheme for qualifying retirees and beneficiaries without the cost-sharing Defendants wrongly imposed. The cap letters were not part of these agreements, and even if they were, they were wholly abandoned.

Thus, contrary to Defendants' assertions, there is no unbroken chain of cap letter applicability. The evidence indicates that Apple Grove is a partial "me too" plant, or a "me too, with exceptions" plant, with the ability to accept or reject such side agreements. The evidence also indicates that Local 644 rejected application of these unpublished agreements. Additionally, chief company negotiator Dick expressly rejected cap letter applicability, and when union negotiator Moore attempted to pull a master agreement's pension multipliers into the negotiation, M & G took the position that the master agreement did not control—a position that undercuts reliance on side agreements that the evidence indicates ultimately applied only to the master agreements.

The first cap letter at issue was in 1991. The evidence does not support that this letter was part of the P & I booklet adopted by Local 644. Testimony indicated that the booklets are prepared after the local's vote. There is no testimony that the agreement terms ratified by the local included cap letters, regardless of the subsequent booklet content. The testimony of Wedge, Moore, Hoover, Pyles, and Tackett indicates that the booklet as published set forth the total

benefits agreement and that it was both permissible and the unwritten policy and practice of Local 644 to adhere to only that which was published in the booklet. Pyles did not testify to knowledge of a cap obtained from a summary plan description; rather, he testified that he did not know of the cap letter and consequently did not ratify it as part of the local agreement. Hoover made clear that a "me too" local could indeed decline to adopt the side agreement letters, and the testimony of Pyles and Tackett indicate that this was the unwritten policy and practice of Local 644. Even James Kruse, whose deposition testimony generally weighed against Plaintiffs in many respects, recognized the divergent nature of the Apple Grove plant. Absent cap letter incorporation into the local P & I agreement, Shell (and consequently, M & G) could not have assumed the cap letter agreement as a successor as part of its purchase of the plant. There is no basis to conclude that the 1991 summary plan description was presented to local members; in any event, a summary cannot itself constitute the terms of the agreement for § 502(a)(1)(B) purposes. Additionally, as Joint Exhibit No. 2 reflects, the express incorporation of specified Goodyear agreements did not include all Goodyear side agreements, pointing to the conclusion that Shell never initially adopted a cap letter.

Neither the 1994 nor 1997 dealings implemented cap letter applicability to the Apple Grove facility. Although deposition testimony by Dale Wunder supports adoption of Letter H in 1997, this conflicts with

the Shell documentary evidence and the more credible testimony of Local 644 members as to what they saw, what they ratified, and how the local approached the incorporation issue. The cap letters at issue were Goodyear cap letters that were not negotiated into the local P & I agreements.

The Court also notes expressly that the evidence concerning the 1997 agreement working copy is not the smoking guns Defendants contend. Instead, as Plaintiffs accurately targeted during trial, this was a Goodyear agreement signed by Goodyear officials who were unable to sign for Shell. The working copy cannot provide a logical basis for cap letter incorporation because when placed in context it is apparent that it was simply that: a copy of an agreement from which the parties could begin their work, with not all parts applicable to the relevant negotiating parties.

In 2000, when Shell sold the Apple Grove plant to M & G, M & G assumed CBA and P & I agreement obligations from Shell. The company's own accountants recognized the retiree benefits as involving no retiree contribution, and there was no booklet incorporation of the cap letter.

It is significant that even if there were at one point cap letter applicability for pre-August 5, 2005 retirees, the parties' dealings extinguished invocation of such retiree contributions. At one point, the union took the position in negotiations that the cap issue was at least potentially relevant, and the union's negotiator recognized the potential applicability of

the cap letter. Testimony explained the prophylactic context of Moore's actions and points to strategic maneuvering that removed any possibility of cap letter applicability. M & G disavowed cap letter applications, the effective contribution date of the relevant hypothetically applicable cap letter expired, and the parties proceeded without the possibility [sic] retiree contributions for existing retirees. Even assuming *arguendo* earlier cap letter applicability, the 2000 P & I agreement cut off any chain of cap letters.

Letter of Understanding 2003-6, dated August 9, 2005, and made part of the 2005-2008 agreement that applies to those plaintiffs in Subclass Five, permits implementation of above-cap retiree contributions. The issue is whether that document looks only forward from August 9, 2005, or indeed presents a permissible, memorialized understanding of existing if previously unimplemented side agreements. Defendants would have this Court accept the proposition that the parties continually kicked the can of retiree contributions down the road until it was no longer economically feasible for the company. The evidence is to the contrary.

Letter of Understanding 2003-6 contemplates caps on employer contributions to retiree health benefits and provides that "premium cost sharing charged to retirees will be based on the amount by which total cost for all retiree insurances (medical, life, etc.) exceed the caps set forth in Letter H dated January 1, 2001." The unilaterally implemented letter also states that retirees would not be required to contribute to

their premiums until January 1, 2006, and that the retiree premium contribution rates would become effective on that date. Defendants argue that Letter of Understanding 2003-6 and the union's history of attempting to negotiate the effective date of caps and to eliminate the application of Letter H point to the application of the caps to M & G. Defendants posit that Letter of Understanding 2003-6 unambiguously supports the unbroken application of caps to retirees (including preexisting retirees). That document explicitly references the prior 2001 cap letter and provides that "[r]etiree benefits" means "benefits for the Company's preexisting retirees." The trial testimony undercuts deeming Letter of Understanding 2003-6 dispositive in Defendants' favor for pre-August 9, 2005 retirees, spouses, and dependents.

This Court concluded that Letter of Understanding 2003-6 does not rehabilitate broken or reaffirm longstanding cap letter applicability in regard to those plaintiffs in Subclasses One through Four. Despite Defendants' best efforts at rewriting history, the trial evidence places the previously ambiguous Letter of Understanding 2003-6 into its proper context as a going-forward document applicable to individuals in Subclass Five and not a document that also speaks to and clarifies the meaning of the prior agreements governing Subclasses One though Four. The actual context of Letter of Understanding 2003-6 does not include a shared intent to vest only partially funded (*i.e.*, capped employer contributions for) lifetime health care benefits to retirees in the first four subclasses.

Rather, the document's context teaches this Court that application of Letter of Understanding 2003-6 to the plaintiffs in the first four subclasses was a unilateral move by M & G to unlawfully circumvent binding agreements to obtain economic advantages. The addition of Letter of Understanding 2003-6 to the 2005-2008 agreement changes the meaning of what constitutes a "full company contribution" from prior agreements so that the clause no longer means the full cost of health-care benefits for qualifying employees, but rather a capped company contribution to the health-care benefits.

To be certain, the parties' decade-plus history of dealing with the cap letters and contributions does not present a model of negotiating clarity, much less competence. On one side, the union's own negotiator once questioned cap letter application, and at least one if not more Local 644 individuals who lacked binding authority appeared not to understand what was involved in the negotiations and the agreements reached. Defendants fare no better. During the 2000 CBA negotiations, attorney David Dick was the lead or chief negotiator for M & G and stated clearly and unequivocally that the cap letter did not apply. The testimony Defendants intend to explain away Dick's purported "confusion" is simply not credible.

Nor is the testimony of Long helpful in regard to applicability. The curiously under-informed Long expressly relied on Korber, whose testimony this Court found to be incredible time and again, in accepting cap letter applicability. Having had ample

opportunity to observe the witness and to consider his testimony, this Court expressly rejects as simply not credible the testimony of Korber, M & G's Human Resources Director, which indicated that M & G had assumed cap letters as part of the preexisting obligations as a successor to Shell. Korber's actions, particularly his communications with the consultant actuaries for M & G, are not consistent with an individual or a company that knew or believed that any cap letter applied. It does not appear to this Court that Korber knew of Letter H until at least 2003, despite his contention that he knew of the cap letter years earlier. Additionally, M & G's own reporting of contribution-free retiree health care benefits (tracking Shell) contradicts the company's post-hoc position that the cap letters always applied and undercuts Korber's self-serving testimony.

In contrast to Korber's testimony, the Court found credible the testimony of Hoover and Moore, who together explained that confusion existed because various locals had different approaches. Potential cap letter application does not equal actual application, and the Court finds that Local 644 never adopted cap letters prior to August 9, 2005, even if union leadership was uncertain about that position at times and had to check in with the home office for assistance during negotiations.

It is also notable that the union lacked the ability to negotiate the vested retiree benefits, a point to which the Court will return below. Previously, this Court noted the examples that Pyles and Tackett did

not consent to the parties addressing this permissive subject of bargaining. *There is no evidence any retiree did.* But there is evidence that union negotiators such as Shipley routinely adopted the position that retiree contributions were not on the table. Only individual union members not in the know apparently believed that the cap letters applied, and they lacked authority to bind the union and the retirees.

As the Court has previously noted, the significant confusion by the parties is odd. It appears that various individuals' efforts to circumvent clarity and full disclosure to the public of self-serving arrangements got a bit too clever for nearly all involved until even key actors were confused by what essentially hidden agreements applied in what context. Goodyear master agreement shenanigans did not necessarily filter down to the me-too with exceptions plant involved here, but the various actors in the history of the Apple Grove plant appear to have been rarely well informed. This is no way to run a business or a union. Companies should know what they are buying (obligations and all), investors should know what company liabilities exist, unions at all levels should be clear on what they are negotiating, and retirees should know what agreements they are ratifying.

Plaintiffs have presented ample evidence involving M & G's counsel, actuaries, and human resources personnel that no one thought that there was a cost-sharing plan in place for Apple Grove retirees for years until it became advantageous to the company. Multiple M & G actors appear at best uncertain of

what benefits liabilities they assumed when they purchased the plant and another expressed a position wholly adverse to cap letter applicability. Those who testified supporting cap letter applicability wholly lacked veracity. Ultimately, this litigation presents a scenario in which a company faced with ballooning benefits costs uncovered a longshot means by which it could attempt to retroactively rewrite agreements to reduce costs—and then the company turned to actuaries to inform the purported scope of the cap letter, apparently basing the claimed scope on the amount of money that could be saved if the company prevailed. This is unlawful.

The issue of liability that once appeared complicated during summary judgment proceedings became far more clear as a result of the trial. And despite real conflicts in evidence, including each party's own at times contradictory evidence, the greater weight of the evidence favors Plaintiffs. For example, the evidence indicates that Dick, the company's chief negotiator and someone with the clear authority to bind the company, rejected cap letter applicability. The company attempts to insulate itself by dubiously disowning his comments and authority, while concurrently pointing to Long's testimony as supporting applicability. Defendants cannot reject one of their negotiators as misinformed and turn to another uninformed negotiator to achieve the continuity of applicability that they seek to prove.

In contrast, the evidence indicates that those with the authority to bind the union disputed cap

letter applicability. The company insists that the Court should credit instead those local members who lacked such binding authority. The evidence indicates that there were no ERISA notices given here, that the retiree benefits issue was not a subject of bargaining, and that the retirees did not consent to negotiations on the issue. The company asks this Court to ignore these facts. The evidence indicates, however, that Defendants developed the contribution scheme as a self-serving response to economic realities and in contravention of the negotiations conducted and applicable agreement reached. This is impermissible under the controlling law.

The plan participants' understanding of what they ratified reflects the benefits agreements reached. This Court therefore concluded: (1) the relevant agreements set forth a scheme in which the employer is responsible for covering the full cost of health-care benefits for those employees meeting the age and term-of-service requirements in Subclasses One through Four; (2) qualifying individuals in Subclasses One through Four are entitled for the company to cover the full cost of the health benefits, without these plaintiffs being required to pay premium contributions; (3) the contribution-free health benefits for individuals in Subclasses One through Four exist despite the fact that various inapplicable side agreements between other parties deferred the eventual collection of retiree contributions; (4) for the plaintiffs in Subclasses One through Four, Defendants have had no right to collect the premiums charged and

have impermissibly terminated benefits for the failure to make such a contribution; and (5) the cap letter applied to Subclass Five, the members of which Defendants could permissibly require to make above-cap contributions. These conclusions speak to the vesting of the right to benefits and not to the benefits themselves.

Having summarized how it determined both that vesting occurred and that the right to lifetime contribution-free health care benefits is what vested, this Court turns to the only real issue that remains after deciding that a permanent injunction is warranted: Should Plaintiffs be reinstated to the pre-2007 versions of the plans? The answer to this question defines part of the scope of the injunction.

There is no real dispute involving two of the three plans involved. The parties apparently agree that the Medical Necessity Plan has remained either unchanged or essentially unchanged so that Plaintiffs do not object to the reinstatement of those dropped from Medical Necessity Plan coverage back into the existing Medical Necessity Plan. Nor do Plaintiffs object to the reinstatement of anyone dropped from the no-longer-existing Catastrophic Plan into the Comprehensive Plan. At the February 15, 2012 hearing, counsel for Plaintiffs indicated that it appears that only one plaintiff falls within this category and that Plaintiffs have no objection to that individual being placed into the Comprehensive Plan.

The issue is into what version of the Comprehensive Plan does the former Catastrophic Plan member and anyone dropped from or currently in the Comprehensive Plan fit. To support their respective positions, both sides direct this Court's attention to the aforementioned *Reese v. CNH America LLC*, 574 F.3d 315, although Plaintiffs emphasize the subsequent district court proceedings that grew out of the Sixth Circuit's remand. Plaintiffs argue that vesting fixed in time at retirement with irreducible benefits, which would mean that reinstatement only into the pre-2007 Comprehensive Plan is proper. Defendants counter that assuming *arguendo* that a right to lifetime contribution-free health care benefits vested, no right to the pre-2007 version of the plan vested.

Curiously, neither side presented much in the way of a substantive case on this issue.[2] For example, when this Court asked Plaintiffs' counsel where in the CBA was there language vesting specific benefits, counsel answered that there was not and only generally directed this Court to the P & I agreements. The P & I agreements set out *some but not all* coverage, and counsel did not identify for the Court *any* specific

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[2] The parties devoted oral argument to whether reinstatement into the prior plans was problematic or even possible. This issue is ultimately a red herring. Any administrative or financial difficulty that would accompany such reinstatement cannot inform the predicate question of whether such reinstatement is called for under the agreements and law involved. If a right to these plans vested, then this Court does not care in this context whether the fulfillment of that right would be difficult.

language in those documents. This approach presents a problem for Plaintiffs for two reasons.

First, the Court is not obligated to guess at what a party's argument is, guess at what an opposing argument is, and then rule on the merits of arguments that the parties have not actually presented. *Cooey v. Kasich*, Nos. 2:04-cv-1156, 2:09-cv-242, 2:09-cv-823, & 2:10-cv-27, 2011 WL 5326141, at *12 n.5 (S.D. Ohio Nov. 4, 2011) (cautioning counsel that "given that this Court is in the business of resolving disputes and not charged with fashioning arguments from nearly random asides, some might argue that informing the Court of the specific arguments asserted and providing supporting authority for the positions taken would be a more prudent litigation strategy"); *Cooey v. Strickland*, No. 2:04-cv-1156, 2009 WL 4842393, at *99 (S.D. Ohio Dec. 7, 2009) (explaining that "this Court cannot fashion an argument that has not been presented to it and then consider that argument as the basis for [injunctive relief]"); *Lyon v. Yellow Transp., Inc.*, No. 2:08-cv-464, 2009 WL 1604807, at *15 (S.D. Ohio June 8, 2009) ("This Court is in the business of resolving the legal arguments presented to it, not in creating a party's inferred argument for him and then passing judgment on it.").

Second, Plaintiffs' strategy does not readily or necessarily align the instant case with the case on which they apparently primarily rely, *Reese v. CNH Global N.V.*, No. 04-70592, 2011 WL 824585 (E.D. Mich. Mar. 3, 2011). In that district court opinion, the trial judge had before it multiple summary

judgment motions and other filings, all of which involved an extensive record consisting of documents that it appears the parties actually discussed. Despite facts strikingly similar to the instant case, the post-remand *Reese* is perhaps of limited value in resolving today's dispute. The language of the agreements at issue in *Reese* was important, as was the parties' course-of-dealing related to benefit plan modifications. The parties in the case *sub judice* have failed to argue the specifics of similar evidence in regard to the motion for a permanent injunction.

There is nevertheless value in the *Reese* proceedings to the instant case. Following the Sixth Circuit's remand in *Reese v. CNH America LLC*, 574 F.3d 315, the retirees seeking benefits filed a petition for rehearing with the court of appeals. The appellate court denied rehearing in *Reese v. CNH America LLC*, 583 F.3d 955 (6th Cir. 2009). One circuit judge, the author of the prior *Reese* appellate opinion, wrote a separate concurrence in which he made several notable points. First, he explained that in regard to the fixed versus changeable benefits debate in *Reese*, "there was evidence that both sets of parties had treated the benefits as changeable with respect to individuals who had retired under prior CBAs." *Id.* at 955 (Sutton, J., concurring). The judge also explained that "it blinked reality to say that the 'vested' benefits were forever unchangeable, given that the parties had allowed them to change, even in some ways that did not favor prior retirees." *Id.* at 956. Finally, in discussing the state of the record in regard

to whether the prior retirees had approved benefits changes, the appellate judge opined that under the panel's remand,

> the parties are free to develop evidence on this point. That evidence may show that plaintiffs should win as a matter of law because the prior retirees either approved the changes or they did not diminish the nature of the benefits package that existed upon retirement. Or it may show that CNH should be allowed to make reasonable modifications to the health-care benefits of retirees, consistent with the way the parties have interpreted and implemented prior CBAs containing similar language.

Id. This interpretation of the remand and relevant law indicates that modifications are appropriate when (1) retirees approve of the changes, (2) the changes do not diminish the *nature* of the benefits (as opposed to any particular benefit itself), or (3) a company makes reasonable changes under a prior course of dealing approach.

On remand, the *Reese* district court treated this construction of the appellate panel's decision as definitive, despite no other panel judge joining the author of the concurrence. 2011 WL 824585, at *7 n.8 (stating that the concurrence shall be treated as clarifying the panel's original decision). This approach was perhaps necessitated by the wording of the panel's remand, which simply provided that "we leave it to the district court to decide how and in what

circumstances [the company] may alter such benefits-and to decide whether it is a matter amendable to judgment as matter of law or not." *Reese*, 574 F.3d at 327. The important point here is that the Sixth Circuit did not remand for a determination of *whether* modifications could occur, but rather for inquiry into *how* and *under what circumstances* modifications could occur. Off the table was the vesting of irreducible benefits. That possible modifications were permitted was now established.

The instance [sic] case is similar to but not the same as *Reese*. The Sixth Circuit found that the *Reese* CBA did not provide fixed and irreducible benefits, although it did provide a vested right to contribution-free benefits. The CBA language at issue here tracks these conclusions. If the CBA in *Reese* did not accomplish such comprehensive vesting, then the essentially analogous CBA here cannot. The extrinsic evidence here, as in the *Reese* trilogy of cases, thus provides the next step in ascertaining the parties' intent.

Although questioning some of the appellate court's conclusions, the *Reese* district judge proceeded on remand to analyze the specific provisions of the relevant agreements in light of the parties' past dealings. That judicial officer concluded that the only circumstances under which the Reese parties allowed modifications to employee health care benefits to occur was through a collectively bargained agreement. 2011 WL 824585, at *10. Thus, the company

could only change benefits through an agreement with the union.[3] *Id.*

Plaintiffs have not put forth evidence to a similar conclusion here. The parties submitted declarations at the hearing that addressed essentially the irreparable harm issue and what benefits plan permutations provided. At trial, evidence repeatedly indicated that the union could not negotiate retiree benefits (even if some union individuals were at times unclear on this point). But modifications to the benefits plan details occurred over time. This indicates no vesting of fixed plan benefits and that the plan was susceptible to reasonable changes. *See Reese*, 574 F.3d at 326 ("We know that the contracting parties viewed the 1995 CBA's benefits as subject to some changes because they changed them."). Because the union lacked the ability to negotiate over the vested retiree benefits, the fact that modifications occurred places this case into a context where changes could and did occur absent company-union negotiation.

There is no evidence that the retirees actively approved of any changes; at best they evinced silent acquiescence to positive modifications or pass-throughs during the course of the me-too relationship. A change that benefits retirees is still a change, even

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[3] The district judge also explained that a shutdown agreement explicitly addressed the ability to modify select retirees' benefits, but no such agreement is involved in the instant case. *Reese*, 2011 WL 824585, at *10.

if "[t]hat sort of change would not break any promises to provide irreducible benefits for life." *Reese*, 574 F.3d at 325. Not all of the modifications at issue here are such upgrades, but the takeaways are nonetheless that the details of the benefits were not fixed and that no individualized negotiations controlled the modifications.

The changes about which Plaintiffs now complain do not diminish the *nature* of the benefits, even if the changes alter the *implementation* of the benefits. Plaintiffs come close to conceding a portion of this proposition when they characterize the change of a $1.00 copay to a $2.00 copay as a pass-through that presents a *de minimus* change that does not constitute a reduction in benefits. (ECF No. 206, at 10.) But that *is* a reduction, even if it may be meager to some individuals. The key point is not the limited effect of the reduction, but that the reasonable reduction does not disturb the essential nature of the benefit provided.[4] A nominal copay is a nominal copay—and its implementation here worked a reduction in benefits that the retirees accepted.

Prior particularized benefits have evolved post-2006 without abandoning the core nature of the benefits. For example, the fact that a covered individual

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[4] Reasonableness is key. For example, an increase from a $1.00 copay to a $10,000.00 copay would reveal the modification to be nothing more than an improper end-run around providing a meaningful benefit.

still gets a limited copay for prescription drugs, even if the copay has evolved from $4 to $10, means that the nature of the core benefit is left untouched while the specific implementation of that benefit now costs those covered more. This is an acceptable result under the law. Of course, the key is the reasonableness of any modification.

Despite the premiums issue, however, M & G to its credit has made reasonable changes implemented under a prior course of dealings approach. In *Reese*, the Sixth Circuit explained that "[c]onsistent with the parties' practices, nothing in the text of [the CBA] said that health-care coverage would be fixed and irreducible into perpetuity for all employees who retired under it." 574 F.3d at 325. This Court invited Plaintiffs' counsel to direct this Court to where the CBA indicates fixed and irreducible coverage into perpetuity and was told in response that the CBA does not. Telling the Court to search the P & I agreements for possible support in that regard is insufficient proof of Plaintiffs' position. As in *Reese*, the context here indicates that "the CBA—unless it says otherwise—should be construed to permit modifications to benefits plans that are 'reasonably commensurate' with the benefits provided in the [CBA]." *Id.* at 326.

Also here, as in *Reese*, "[n]or did the statements of company representatives to retirees show that these benefits were unalterable as a matter of law." *Id.* Plaintiffs should have directed this Court to such statements and no doubt would have if they could have. They did not.

Ultimately, then, this case echoes the Sixth Circuit's summary of the *Reese* context in which "the retirees have a vested right to receive health care benefits for life." *Id.* at 327. As in *Reese*, the proposition that "these benefits must be maintained precisely at the level provided for in the [CBA], * * * is not supported by the [CBA], extrinsic evidence provided by the parties or common sense. [The company], in short, cannot terminate all health-care benefits for retirees, but it may reasonably alter them." *Id.* Earlier in its opinion, the Sixth Circuit explained the rationale underlying the changeable nature of a vested right to benefits:

> The language of health-care provisions, as the 1998 CBA illustrates, generally does not contain the kind of precision that characterizes a pension plan. "Employees," it says, "who retire under the Case Corporation Pension Plan for Hourly Paid Employees after 7/1/94, or their surviving spouses eligible to receive a spouse's pension under the provisions of that Plan, shall be eligible for" health-care benefits. JA 1288. It is one thing to say that this kind of language, when tied to eligibility for a pension plan, prevents an employer from *terminating* the benefits—which we have held here. It is quite another to say that an employer may not *alter* the benefits in any way, particularly when the parties have a history of doing just that and when common experience suggests that health-care plans invariably change over time, if not from year to year. *See Diehl v.*

> *Twin Disc, Inc.*, 102 F.3d 301, 309 (7th Cir. 1996) (distinguishing a promise to provide "lifetime insurance benefits" from "decid[ing] precisely what those benefits are").

Id. at 324. Such guidance informs today's decision.

Plaintiffs' right to contribution-free benefits vested, but as *Reese* teaches in construing similar contractual language, no specific benefit plan details vested. The parties' course of dealing reveals that the specific details of the health care benefits were and are changeable and that retirees accepted modifications in the past. The past informs the present, so that this Court must conclude that reinstatement into the current version of the health care plans is appropriate, subject to any concession on the part of Plaintiffs such as in regard to the Catastrophic Plan member who will be reinstated into the Comprehensive Plan without Plaintiffs' objection.

III.

For the foregoing reasons, the Court **GRANTS** Plaintiffs' motion for a permanent injunction, but declines to adopt the exact scope of the injunction requested. (ECF No. 196.) The Court therefore **ORDERS**:

(1) within forty-five days following the filing of this Opinion and Order, Defendants shall reinstate all retirees, their spouses, and surviving spouses or other dependents who were enrolled in the Medical Necessity Plan back into the Medical Necessity Plan;

(2) within forty-five days following the filing of this Opinion and Order, Defendants shall reinstate all retirees, their spouses, and surviving spouses or other dependents who were enrolled in the Catastrophic Plan into the current Comprehensive Plan;

(3) within forty-five days following the filing of this Opinion and Order, Defendants shall reinstate all retirees, their spouses, and surviving spouses or other dependents who were enrolled in the Comprehensive Plan into the current Comprehensive Plan;

(4) Defendants shall maintain plan membership for all retirees, their spouses, and surviving spouses or other dependents who are currently enrolled in either the Medical Necessity Plan or the Comprehensive Plan; and

(5) as of the date of the filing of this Opinion and Order, Defendants shall cease collecting from and charging any premiums to Plaintiffs.

IT IS SO ORDERED.

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561 F.3d 478

Hobert TACKETT, et al., Plaintiffs-Appellants,
v.
M & G POLYMERS, USA, LLC, et al., Defendants-Appellees.

Nos. 07-4515, 07-4516.

United States Court of Appeals,
Sixth Circuit.

Argued: Jan. 22, 2009.
Decided and Filed: April 3, 2009.

ARGUED: Renate Klass, Martens, Ice, Klass, Legghio & Israel, Royal Oak, Michigan, Robert E. Rickey, Cook, Portune & Logothetis, Cincinnati, Ohio, for Appellants. Deborah Shannon Davidson, Morgan, Lewis & Bockius, Chicago, Illinois, for Appellees. ON BRIEF: Renate Klass, Stuart M. Israel, Martens, Ice, Klass, Legghio & Israel, Royal Oak, Michigan, Robert E. Rickey, David M. Cook, Cook, Portune & Logothetis, Cincinnati, Ohio, for Appellants. Deborah Shannon Davidson, Philip A. Miscimarra, Morgan, Lewis & Bockius, Chicago, Illinois, for Appellees.

Before: MARTIN and MOORE, Circuit Judges; GWIN, District Judge.*

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* The Honorable James S. Gwin, United States District Judge for the Northern District of Ohio, sitting by designation.

OPINION

PER CURIAM.

The Plaintiffs United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC ("USW") and Hobert Tackett, Woodrow W. Piles, and Harlan B. Conley ("Retiree Plaintiffs") separately appeal the district court's dismissal of their case under Federal Rule of Civil Procedure 12(b)(1) and (b)(6).

The Plaintiffs alleged that, under their collective bargaining agreement ("CBA"), the Defendant M & G Polymers, USA ("M & G") promised them vested health-care benefits. When Defendant M & G announced it would begin requiring retiree contributions to health-care costs, the Plaintiffs sued. In addition to suing M & G, the Plaintiffs also sued the M & G-sponsored health plans that Retiree Plaintiffs receive their benefits from: the M & G Comprehensive Medical Benefits Program for Employees and Their Dependents, the M & G Catastrophic Medical Plan, the M & G Medical Necessity Benefits Program of Hospital, Surgical, Medical, and Prescription Drug Benefits for Employees and Their Dependents, and the M & G Major Medical Benefits Plan (collectively, with Defendant M & G, "Defendants").

In resolving this appeal, we must decide two main issues: (1) whether, under § 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185(a), a district court must find that a violation of

a collective bargaining agreement has occurred before it can exercise jurisdiction; and (2) whether, under this Circuit's *Yard-Man* analysis, *UAW* v. *Yard-Man*, 716 F.2d 1476, 1479 (6th Cir. 1983), the Plaintiffs have sufficiently established a right to vested healthcare benefits to survive a motion to dismiss under Rule 12(b)(6) by relying on CBA language promising a "full Company contribution" to these benefits.

Because we hold that (1) a violation is not a prerequisite to jurisdiction under § 301 and because (2) the Plaintiffs have sufficiently shown an intention to vest healthcare benefits to survive a motion to dismiss, we **REVERSE** and **REMAND**.

I. Standard of Review

We generally review a district court's ruling under Rule 12(b)(1) and 12(b)(6) *de novo*. *Nichols v. Muskingum College*, 318 F.3d 674, 677 (6th Cir. 2003) (citations omitted); *Ass'n of Cleveland Fire Fighters v. City of Cleveland, Ohio*, 502 F.3d 545, 548 (6th Cir. 2007). Courts have, however, observed an exception to this *de novo* standard of review under Rule 12(b)(1). When Congress statutorily confers subject-matter jurisdiction, it can require that certain prerequisites be met before a federal district court can exercise jurisdiction. *See, e.g.*, 28 U.S.C. § 1332 (establishing jurisdiction over cases between "citizens of different States"). When Congress establishes a jurisdictional prerequisite, a district court may admit extrinsic evidence and resolve disputed facts to decide

if the asserted claim satisfies the jurisdictional prerequisite. *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 516, 126 S. Ct. 1235, 163 L. Ed. 2d 1097 (2006). If a district court considers and resolves facts in deciding a Rule 12(b)(1) motion, we review those findings for clear error. *Nichols*, 318 F.3d at 677. Aside from the resolution of jurisdictional prerequisites, a district court must generally confine its Rule 12(b)(1) or 12(b)(6) ruling to matters contained within the pleadings and accept all well-pleaded allegations as true. *Gentek Building Products, Inc. v. Sherwin-Williams*, 491 F.3d 320, 330 (6th Cir. 2007).

II. Background and Procedural Posture

Before their retirement, the Retiree Plaintiffs worked at the Point Pleasant Polyester Plant (the "Plant") in Apple Grove, West Virginia. At that location, Plaintiff USW, or its predecessor union, bargained on behalf of the Plant's employees. The Plant has changed ownership several times, and M & G now owns the plant.

In December 2006, M & G announced that it would begin requiring retirees to contribute to the cost of their health-care benefits. After Defendant M & G's announcement, Retiree Plaintiffs, as putative class representatives, and USW sued under § 301 of the LMRA and under the Employee Retirement Income Security Act ("ERISA") §§ 502(a)(3) and 502(a)(1)(B), 29 U.S.C. § 1132. Following the district court's dismissal, the Plaintiffs appealed separately,

with USW challenging the district court's ruling on § 301 and the Retiree Plaintiffs challenging the ruling on both § 301 and ERISA §§ 502(a)(3) and 502(a)(1)(B). The appeals were consolidated for submission to this Court.

In their Complaint, the Plaintiffs pointed to language in the November 6, 2000 CBA between M & G and USW that governed retirees' entitlement to health-care benefits:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan * * * whose full years of attained age and full years of attained continuous service * * * at the time of retirement equals 95 or more points *will receive a full Company contribution towards the cost of [health-care] benefits* * * * * Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health care] benefits * * * * Failure to pay the required medical contribution will result in cancellation of coverage.

(emphasis added). According to the Plaintiffs, this "full Company contribution" language shows a vested right to health-care benefits: those employees meeting the age and term-of-service qualifications are

entitled to fully-covered health care benefits and those falling below these qualifications would receive reductions from full coverage as set out in the plan. The Retiree Plaintiffs also sought to represent surviving spouses whose benefits were affected by Defendants' alleged breach. The Plaintiffs said that the Defendants unilaterally set the "contribution" at a level below full coverage violating the above-quoted language.

The Defendants moved to dismiss the Complaint under Rule 12(b)(1) and 12(b)(6). The Defendants argued that, § 301, which confers subject-matter jurisdiction in federal district courts in "[s]uits for violation of contracts," 29 U.S.C. § 185(a), required that a plaintiff show a "violation" before a district court could exercise subject-matter jurisdiction. In the alternative, the Defendants moved to dismiss saying that the language quoted by the Plaintiffs did not establish a vested right to health-care benefits.

In moving to dismiss, the Defendants submitted evidence of several side letter agreements. Defendants said that these side letters were incorporated by reference into the CBA that the Plaintiffs sued under and that the side letters cap the amount of the employer's contribution to the cost of health-care benefits. Responding, the Plaintiffs said that these side cap letters were not part of the collective bargaining agreement that the Plaintiffs sued under. Resolution of this disputed issue, however, required

consideration of materials extrinsic to the pleadings.[1] The Defendants said that the district court could consider this extrinsic material under Rule 12(b)(1) because the court found a lack of a violation, which was a jurisdictional prerequisite.

The district court agreed with the Defendants and held that the showing of a collective bargaining agreement violation was a prerequisite to jurisdiction: "Absent a breach by Defendants, this Court lacks jurisdiction over the § 301 claim." *Tackett v. M & G Polymers USA, LLC.*, 523 F. Supp. 2d 684, 691 (S.D. Ohio 2007). The court then admitted and weighed the extrinsic evidence on the side letters to decide whether M & G breached the collective

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[1] In support of the contention that the side letters were incorporated into the CBA, the Defendants submitted evidence of the collective bargaining history at the Plant dating back to 1991. A series of collective bargaining agreements has been in force at the Plant, with each typically lasting around three years before renegotiation. The first letter agreement, signed contemporaneously with the 1991-1994 collective bargaining agreement, was adopted "for purposes of conforming with the new Financial Accounting Standard Board (FASB) accounting requirement" that required accrual accounting of healthcare benefits. This new requirement hurt a company's balance sheet performance if the company had no cap on its health-care costs. While signed in 1991, the caps were not to take effect until July 1, 1997. Concurrent with the 1994-1997 collective bargaining agreement, another cap letter postponed the effective date of the caps to 2004. The import of this perpetual postponement and the applicability of these cap letters to the current parties are fact issues that must be resolved by the district court outside of the Rule 12(b)(1) determination.

bargaining agreement.[2] *Id.* at 690. Ultimately, the district court concluded that the Defendants did not breach the CBA, and that it lacked jurisdiction.

As an alternative to its dismissal for lack of jurisdiction, the district court then assumed for argument purposes that it had jurisdiction over the Plaintiffs' claims for relief and addressed the Defendants' 12(b)(6) motion to dismiss. Because the LMRA § 301 and the ERISA § 502(a)(1)(B) claims both turned on whether the Plaintiffs' benefits were vested, the district court considered these claims together and held that the "full Company contribution" language did not plausibly state a claim for vested healthcare benefits.

The district court additionally granted the Defendants' 12(b)(6) motion directed at the Plaintiffs' ERISA fiduciary claim, holding that Plaintiffs "failed to plead facts" supporting this claim. *Id.* at 696.

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[2] For example, the Plaintiffs submitted to the district court a letter written by David Dick, an attorney who represented M & G in labor negotiations in 2000. The letter said that the applicability of one of the cap letters to "M & G is less than clear. In fact, the Company believes it does not apply to M & G." During this litigation, however, Dick submitted a declaration saying he "was not familiar with details or history concerning any side letters." In resolving the Defendants' Rule 12(b)(1) motion, the district court accepted Dick's characterization of the letter and found that this letter "was the result of a lack of understanding on [Dick's] part of the history of cap incorporation." *Tackett*, 523 F. Supp. 2d at 690.

III. Rule 12(b)

III.A. Rule 12(b)(1)

Our review of the district court's dismissal under Rule 12(b)(1) turns on whether a plaintiff must establish the breach of a collective bargaining agreement as a prerequisite to jurisdiction under § 301 of the LMRA.[3] The LMRA confers subject-matter jurisdiction in federal district courts in "[s]uits for violation of contracts." 29 U.S.C. § 185(a).[4] Whether the language in a statute like § 301 is a jurisdictional prerequisite or merely an "'essential ingredient[ ] of a federal claim for relief'" is sometimes a "'close question.'" *Arbaugh*, 546 U.S. at 503, 516, 126 S. Ct. 1235

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[3] The Plaintiffs also claimed that the district court had federal-question subject-matter jurisdiction under 28 U.S.C. § 1331. Here, the district court dismissed the claim because it failed to meet the requirements of § 301. We, however, ultimately conclude that the court had jurisdiction under § 301. Accordingly, we need not address whether 28 U.S.C. § 1331 could support jurisdiction over the Plaintiffs' claims if the claims had failed to meet a jurisdictional requirement of § 301.

[4] In full, § 301 says,

> Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties.

29 U.S.C. § 185(a).

(quoting *Da Silva v. Kinsho Intern. Corp.*, 229 F.3d 358, 361 (2nd Cir. 2000)).

If a violation is not a prerequisite to jurisdiction, then, to survive a Rule 12(b)(1) motion, the Plaintiffs need not show a violation but merely that their violation claim is "colorable." *Id.* at 513, 126 S. Ct. 1235 (citing *Bell v. Hood*, 327 U.S. 678, 681-85, 66 S. Ct. 773, 90 L. Ed. 939 (1946)). Additionally, if a violation is not a prerequisite to jurisdiction, the district court erred in admitting and weighing evidence extrinsic to the pleadings in resolving the Rule 12(b)(1) motion.

III.A.1. The Distinction between a Jurisdictional Prerequisite and an Essential Ingredient of a Federal Claim to Relief

In finding that it did not have jurisdiction over Plaintiffs breach of contract claim, the district court relied upon *Bauer v. RBX Industries, Inc.*, 368 F.3d 569 (6th Cir. 2004). Giving *Bauer* an exceedingly broad reading, the district court held that plaintiffs in a § 301 action must demonstrate a contractual violation to establish jurisdiction. *Tackett*, 523 F. Supp. 2d at 691-92. The district court's interpretation of *Bauer* was over-broad. More importantly, the Supreme Court and this Court have both subsequently rejected the district court's requirement.

After the *Bauer* decision, the Supreme Court clarified the distinction between a jurisdictional prerequisite and an essential ingredient of a federal

claim to relief and provided a test that courts must use to determine what showing is required to establish jurisdiction and what showing is required to establish the merits of their claims. In *Arbaugh*, the plaintiff sued for alleged violations of Title VII. *Id.* at 503-04, 126 S. Ct. 1235. Title VII says that "[e]ach * * * United States district court * * * shall have jurisdiction of actions brought under this subchapter." *Id.* at 505-06, 126 S. Ct. 1235 (citing 42 U.S.C. § 2000e-5(f)(3)). Title VII "makes it unlawful 'for an employer * * * to discriminate,' * * * on the basis of sex." *Id.* at 503, 126 S. Ct. 1235 (citing 42 U.S.C. § 2000e-2(a)(1)). Separately, Title VII defines "employer" to only include those employers with "fifteen or more employees." *Id.* at 504, 126 S. Ct. 1235 (citing 42 U.S.C. § 2000e(b)). The central issue in *Arbaugh* was whether this statutory "employee-numerosity requirement" was a "jurisdictional" prerequisite, or merely an "essential ingredient[ ]" of the plaintiff's claim. *Arbaugh*, 546 U.S. at 513, 126 S. Ct. 1235.

In resolving this central issue, the Arbaugh Court first criticized the frequent sloppiness in courts' treatment of motions to dismiss, noting that courts too often "conflated" Rule 12(b)(6) merits motions with Rule 12(b)(1) jurisdictional motions. *Id.* at 511, 126 S. Ct. 1235. To remedy this, the Supreme Court established a bright line rule:

> If the Legislature *clearly states* that a threshold limitation on a statute's scope shall count as jurisdictional, then courts and litigants will be duly instructed and will not

> be left to wrestle with the issue * * * * But *when Congress does not rank a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional in character.*

Id. at 515-16, 126 S. Ct. 1235 (citations omitted) (emphasis added).

In determining whether Congress intended courts to treat the employee numerosity requirement as jurisdictional, the Supreme Court noted that Title VII gave no indication that a district court should raise and resolve the employee-numerosity requirement on its own. *Id.* at 514, 126 S. Ct. 1235.

In concluding that Congress did not intend to rank the employee-numerosity requirement as jurisdictional, the Court identified two additional practical considerations that supported its holding: the discretion that district courts enjoy when their fact-finding overlaps with the merits of the claims and judicial efficiency. *Id.* A district court can resolve disputed facts that underlie a jurisdictional prerequisite in a 12(b)(1) motion, but when the prerequisite is intertwined with the merits, this fact-finding undercuts the jury's role as the "proper trier of contested facts." *Id.* Additionally, because subject-matter jurisdiction defects can be raised at any stage of litigation, and because a lack of subject-matter jurisdiction requires dismissal of pendent state-law claims, a district court may be required to dismiss state claims after expending considerable judicial resources. *Id.*

III.A.2. Application of Arbaugh in the Sixth Circuit

After oral argument in this case, this Court reexamined *Bauer* and its § 301 jurisprudence in light of the *Arbaugh* decision. *Winnett v. Caterpillar, Inc.*, 553 F.3d 1000, 1004-07 (6th Cir. 2009). In *Winnett*, this Court overruled the *Bauer* decision and held that "the existence of a union contract is an element of Plaintiffs' merits claim, not a limit on federal subject-matter jurisdiction." *Id.* at 1007.

In reaching this decision, the *Winnett* Court started with an examination of Congressional intent. *Id.* at 1005-06 ("*Arbaugh* now tells us to ask: Did Congress 'clearly state[ ],' 546 U.S. at 515, 126 S. Ct. 1235, that the existence of a union contract is a jurisdictional prerequisite for a Section 301(a) claim?"). In determining whether Congress intended a contract to be a jurisdictional prerequisite, the Court noted that the only reference to jurisdiction in § 301 was to personal jurisdiction and in that reference the statute had not "impose[d] new barriers" to federal courts, but had "ease[d] access." *Id.* at 1006. Additionally, § 301 includes all of the prima facie elements of the cause of action in the jurisdiction-conferring provision. The Court reasoned that, if a contract is a jurisdictional prerequisite, then likely each other prima facie requirement in § 301 functions as a jurisdictional prerequisite. The *Winnett* Court was "reluctant to conclude that Congress intended to create a cause of action that has no non-jurisdictional elements." *Id.*

After finding no indication that Congress "clearly state[d]" that courts should treat a contract as jurisdictional, the Court went on to address the "real-world considerations" associated with treating a contract as jurisdictional. *Id.* This additional analysis after examining Congressional intent was drawn from the *Arbaugh* decision: "*Arbaugh* also tells us not to just look at labels but also pragmatically to consider the consequences of giving a jurisdictional label to an element of a cause of action." *Id.* The *Winnett* Court then pointed out that, when a district court finds a jurisdictional defect, the court must dismiss even meritorious pendent state-law claims, despite the time and resources the court and parties have expended on the case. *Id.* at 1007 (noting the "wasteful inefficiencies on the parties or the courts").

As directed by the Supreme Court in *Arbaugh* and the *Winnett* Court, we conclude that Congress did not "clearly state[ ]" an intent to treat the violation language as jurisdictional. *See id.* at 1005-06. Additionally, after examining the "real-world considerations" of labeling the violation language as jurisdictional, we find the district court's interpretation would wreak havoc. *See id.* at 1006.

The *Winnett* Court has already determined that Congress did not intend the "contract" language in § 301 as jurisdictional. We agree and hold that Congress did not "clearly state[ ]" that courts should treat the violation language as jurisdictional for the same reasons identified by the *Winnett* Court. The language of § 301 suggests that a violation is not a

prerequisite to jurisdiction: "Suits *for violation* of contracts * * * may be brought in any district court of the United States having jurisdiction of the parties * * * * *" 29 U.S.C. § 185(a) (emphasis added.) If we were to consider a violation a jurisdictional prerequisite, Congress would be requiring a district court to determine whether a violation had occurred before it could decide at the merits stage whether a violation had occurred. This cannot be the result intended by Congress with the use of the violation language.

This conclusion is bolstered here, even more so than in *Winnett*, by the "real-world considerations" associated with labeling a violation as a jurisdictional prerequisite. *Winnett*, 553 F.3d at 1006. First, the LMRA gives the district court jurisdiction over "[s]uits *for* violation of contracts." Section 301 does not limit jurisdiction to "suits where a violation of contract has been established." The district court will consider the same set of underlying facts when deciding if there was a violation to support jurisdiction and when deciding if the Plaintiffs should ultimately succeed on the merits of their claim. Any merits-related fact-finding by a district court during a jurisdictional determination undercuts the jury's traditional role as "the proper trier of contested facts." *See Arbaugh*, 546 U.S. at 514, 126 S. Ct. 1235 (citations omitted).

Second, as both *Winnett* and *Arbaugh* noted, "when a court lacks subject matter jurisdiction over a claim, it must immediately dismiss not just that claim but any pendent state-law claims as well—no

matter how late in the case the district or appellate court identifies the jurisdictional defect." *Winnett*, 553 F.3d at 1007 (citing *Arbaugh*, 546 U.S. at 514, 126 S. Ct. 1235). For example, a case may go all the way to a jury trial on a § 301 claim and pendent state-law claims. If the jury finds that the state-law claims are meritorious but also that a plaintiff did not establish a violation of a labor contract, the court would be required to dismiss these meritorious state-law claims after expending considerable judicial resources on their adjudication. This required dismissal may "impose * * * wasteful inefficiencies on the parties or the courts." *Id.*

These inefficiencies become exacerbated in the context of a § 301 action. In *Charles Dowd Box Co. v. Courtney*, 368 U.S. 502, 502, 82 S. Ct. 519, 7 L. Ed. 2d 483 (1962), the Supreme Court addressed concurrent federal and state court jurisdiction over claims for a violation of a collective bargaining agreement. The Court held that state courts have concurrent jurisdiction over § 301 claims. *Id.* at 521-22, 82 S. Ct. 519 ("We agree with the Supreme Judicial Court of Massachusetts that the courts of that Commonwealth had jurisdiction in this case, and we accordingly affirm the judgment before us."); *see also, Valinski v. Detroit Edison*, 197 F. App'x 403, 407 (6th Cir. 2006) ("State courts have concurrent jurisdiction over § 301 claims, but must of course apply federal law."). If Plaintiffs' claim for breach of contract is dismissed for lack of jurisdiction, res judicata does not prevent relitigation of the breach of contract claim in a state

court with plenary jurisdiction. *See* 18A CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 4436 ("The basic rule that dismissal for lack of subject-matter jurisdiction does not preclude a second action on the same claim is well settled.").

Accordingly, we hold that the district court erred in dismissing the Plaintiffs' claims for lack of subject-matter jurisdiction.[5]

III.B. Rule 12(b)(6)

After dismissing the Plaintiffs' LMRA claim for lack of jurisdiction, the district court then assumed that it had jurisdiction and dismissed the Plaintiffs' complaint for failure to state a claim. We now address the district court's grant of the Defendants' 12(b)(6) motion. The district court "decline[d] to consider material extrinsic to the pleadings in regard to the motion to dismiss," and therefore did not convert the 12(b)(6) motion into a motion for summary judgment. *Tackett*, 523 F. Supp. 2d at 693.[6]

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[5] The Defendants ask this Court to affirm the district court's holding under Rule 12(b)(1) because the Plaintiffs have failed to present a colorable claim. We need not address this argument because below we conclude that the Plaintiffs have sufficiently stated a claim under the more rigorous Rule 12(b)(6) standard.

[6] The district court noted the "unusual" procedural posture of the case, which allowed the court to consider the Letter

(Continued on following page)

The Defendants say that we should affirm that district court's 12(b)(6) ruling, or, alternatively, convert this into a Rule 56 motion and consider materials outside the pleadings. The Defendants say that conversion is appropriate because both parties submitted, and the district court considered, extrinsic materials in the Rule 12(b)(1) analysis.

Under our 12(b)(1) analysis above, we did not consider matters outside the pleadings. Rule 12(b)(6), besides some minor exceptions, does not permit courts to consider evidence extrinsic to the pleadings. *See Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 127 S. Ct. 2499, 2509, 168 L. Ed. 2d 179 (2007) (citing 5B WRIGHT & MILLER § 1357). If, however, as the Defendants urge, we convert the 12(b)(6) motion into a Rule 56 motion, we would need to examine all of the extrinsic materials the parties submitted. Accordingly, we will first address whether such an examination is necessary, and decide if the Defendants' Rule 12(b)(6) motion should be converted into a Rule 56 motion on appeal.

III.B.1. Rule 12(d) Conversion

When a court considers matters outside the pleadings in a Rule 12(b)(6) motion, Rule 12(d) requires that "the motion must be treated as one for summary judgment under Rule 56." FED. R. CIV. P.

Agreements in a 12(b)(1) motion, but not in the 12(b)(6) motion. *Tackett*, 523 F. Supp. 2d at 692.

12(d). A district court may convert the motion *sua sponte*. This conversion, however, "should be exercised with great caution and attention to the parties' procedural rights." 5C WRIGHT & MILLER § 1366.

In the Sixth Circuit, before a district court may convert the motion *sua sponte*, the "district court must afford the party against whom *sua sponte* summary judgment is to be entered ten-days notice and an adequate opportunity to respond." *Yashon v. Gregory*, 737 F.2d 547, 552 (6th Cir. 1984). Despite this "clearly established rule," an appeals court will reverse for failure to notify only if the losing party can "demonstrate prejudice." *Id.*; *Harrington v. Vandalia-Butler Bd. of Educ.*, 649 F.2d 434, 436 (6th Cir. 1981) ("A District Court's failure to comply with the ten-day requirement of Rule 56(c) is subject to the harmless error rule.").

Yashon states that the notice requirement is flexible and that a failure to give notice will result in reversal only if there was sufficient prejudice to the non-moving party. *See* 5C WRIGHT & MILLER § 1366 ("[T]he absence of formal notice will be excused when it is harmless or when the parties were otherwise apprised of the conversion * * * and, in fact, had a sufficient opportunity to present the materials relevant to a summary judgment motion.").

In asking this court to convert the 12(b)(6) motion *sua sponte*, the Defendants point to *Cunningham v. Osram Sylvania, Inc.*, 221 F. App'x 420, 423 (6th Cir. 2007), an unreported Sixth Circuit opinion where

the district court granted the defendant's 12(b)(6) motion to dismiss, but considered materials extrinsic to the pleadings. On appeal, the parties conceded that, although the district court decided the motion under Rule 12(b)(6), "a decision under Rule 56 was appropriate." *Id.* This Court did not reverse because the district court committed a "technical error" and merely mislabeled its analysis: the district court's decision was the "functional equivalent" of a Rule 56 determination. *Id.*

Cunningham involved the review of a district court opinion that was the "functional equivalent" of a ruling under Rule 56. The merits analysis presented here under Rule 12(b)(1), however, was not at all the functional equivalent of a Rule 56 determination. Here, the district court weighed and resolved the claim without viewing "the facts, and all inferences to be drawn from them, in the light most favorable to the nonmoving party." *Abercrombie & Fitch Stores, Inc. v. Am. Eagle Outfitters, Inc.*, 280 F.3d 619, 629 (6th Cir. 2002) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986)). Additionally, the district court made no conclusions regarding whether the claim presented any "genuine issue as to any material fact." FED. R. CIV. P. 56(c).

Because the district court's ruling was not the functional equivalent of a Rule 56 ruling, we decline the Defendants' invitation to base our ruling on Rule 56. Therefore, we will not consider matters extrinsic

to the pleadings and we will proceed to review the district court's Rule 12(b)(6) analysis.

III.B.2. Rule 12(b)(6) Standard

In deciding a Rule 12(b)(6) motion, a district court must (1) view the complaint in the light most favorable to the plaintiff and (2) take all well-pleaded factual allegations as true. *Gunasekera v. Irwin*, 551 F.3d 461, 466 (6th Cir. 2009) (citations omitted). But the district court need not accept a "bare assertion of legal conclusions." *Columbia Natural Res., Inc. v. Tatum*, 58 F.3d 1101, 1109 (6th Cir. 1995).

In *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 127 S. Ct. 1955, 1974, 1965, 167 L. Ed. 2d 929 (2007), the Supreme Court said that, when viewing the complaint under the above standards, to survive a motion to dismiss a complaint must contain (1) "enough facts to state a claim to relief that is plausible," (2) more than "a formulaic recitation of a cause of action's elements," and (3) allegations that suggest a "right to relief above a speculative level."

Just weeks after the *Twombly* decision, however, the Supreme Court cited *Twombly* to reaffirm the liberal pleading standard in Rule 8(a)(2): "Rule * * * 8(a)(2) requires only a 'short and plain statement of the claim showing that the pleader is entitled to relief.' Specific facts are not necessary; the statement need only 'give the defendant fair notice of what the * * * claim is and the grounds upon which it rests.'" *Erickson v. Pardus*, 551 U.S. 89, 127 S. Ct. 2197, 2200,

167 L. Ed. 2d 1081 (2007) (quoting *Twombly*, 127 S. Ct. at 1964). On several occasions, the Sixth Circuit has identified "uncertainty regarding the scope of *Twombly*," and noted that *Twombly* may be "limited to expensive, complicated litigation." *Gunasekera*, 551 F.3d at 466. In reviewing a motion to dismiss, "[w]e read *Twombly* and *Erickson* in conjunction with one another." *Sensations, Inc. v. City of Grand Rapids*, 526 F.3d 291, 295-96 (6th Cir. 2008).

We will now address whether the Plaintiffs have sufficiently pleaded their LMRA and ERISA claims to survive a Rule 12(b)(6) motion.

III.B.2.a. Section 301 Pleading Sufficiency

The parties dispute whether the Plaintiffs have plausibly alleged a violation of the CBA. The Plaintiffs allege that Defendants unilaterally modified the Plaintiffs' vested health-care benefits. Health-care benefits vest only if the parties so intend. *Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008). If the parties do not intend to vest the benefits, the former employer can modify the retiree benefits without breaching a collective bargaining agreement.

In determining whether the parties intended health care benefits to vest, this Court applies the principles first described in *UAW v. Yard-Man*, 716 F.3d 1476, 1479 (6th Cir. 1983). In *Yard-Man*, we held that, when interpreting a collective bargaining agreement, a court must start with the "explicit language." *Id.* General principles of contract interpretation

should guide a district court's interpretation of the explicit language.[7] "When a contractual provision is ambiguous, the court may turn to extrinsic evidence." *UAW v. BVR Liquidating, Inc.*, 190 F.3d 768, 774 (6th Cir. 1999). Language in a collective bargaining agreement that "equate[es] eligibility for retiree health benefits with eligibility for a pension" suggests an intent to vest. *McCoy v. Meridian Auto. Sys., Inc.*, 390 F.3d 417, 421 (6th Cir. 2004) (citing *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996)).

Courts reviewing a collective bargaining agreement must also keep in mind the context of labor-management negotiations on retiree health-care benefits: "because retirement health care benefits are not mandatory or required to be included in an agreement, and because they are 'typically understood as a form of delayed compensation or reward for past services' it is unlikely that they would be 'left to the contingencies of future negotiations.'" *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 580 (6th Cir. 2006) (quoting *Yard-Man*, 716 F.2d at 1481-82).

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[7] In interpreting a CBA, courts must (1) "look to the explicit language," (2) evaluate that language "in light of the context" that led to its use, (3) "interpret each provision * * * as part of the integrated whole," (4) construe each provision "consistently with the entire document and the relative positions and purposes of the parties," (5) construe the terms "so as to render none nugatory" and to "avoid illusory promises," (6) look to other words and phrases in the document to resolve ambiguities, and (7) "review the interpretation * * * for consistency with federal labor policy." *Yard-Man*, 716 F.2d at 1479-80.

Here, the Plaintiffs have pointed to language in the collective bargaining agreement sufficient to survive a 12(b)(6) motion. In their Complaint, the Plaintiffs pointed to language in the November 6, 2000 CBA between M & G and the USW:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan * * * whose full years of attained age and full years of attained continuous service * * * at the time of retirement equals 95 or more points *will receive a full Company contribution towards the cost of [health-care] benefits* * * * * Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health-care] benefits * * * * Failure to pay the required medical contribution will result in cancellation of coverage.

(emphasis added).

The district court held that the "full Company contribution" language meant "that qualifying retirees will receive the total amount of the company's *potential* contribution toward the cost of health benefits." *Tackett*, 523 F. Supp. 2d at 695. The district court found that the language, "[e]mployees will

be required to pay the balance of the health care contribution," supported its reading. *Id.* at 696.

We disagree with the district court's reading of the relevant portions of the CBA. First, the "full Company contribution" language suggests that the parties intended the employer to cover the full cost of health-care benefits for those employees meeting the age and term-of-service requirements. Keeping in mind the context of the labor-management negotiations identified in *Yard-Man*, we find it unlikely that Plaintiff USW would agree to language that ensures its members a "full Company contribution," if the company could unilaterally change the level of contribution. The CBA has no limitation on the amount of a company contribution and if the Defendants' argument were accepted, the company presumably could lower the contribution to zero without violating this language. Such a promise would be illusory.

Second, the limiting language, "[e]mployees will be required to pay the balance of the health care contribution," follows the provision requiring contributions by those retirees who had not attained the requisite seniority points. From the placement of this language, we can reasonably infer that it did not apply to all retirees, but only to those retirees who had not attained the requisite seniority points.

Third, the collective bargaining agreement tied eligibility for health-care benefits to pension benefits. This is another factor indicating that the parties

intended the health care benefits to vest upon retirement.

We hold that the Plaintiffs' Complaint presented a plausible claim that the parties intended to vest health-care benefits. Accordingly, we hold that the district court erred in granting the Defendants' Rule 12(b)(6) motion on the § 301 claim.

III.B.2.b. Sufficiency of Pleadings for ERISA § 502(a)(1)(B) Violation of Employee Welfare Benefit Plan Claim

ERISA § 502(a)(1)(B) allows a plan "participant or beneficiary" to bring a civil action to "recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132.

As noted above in the discussion of § 301, health-care benefits, as opposed to pension benefits, do not mandatorily vest. *Sprague v. Gen. Motors*, 133 F.3d 388, 400 (6th Cir. 1998) (en banc). Employers, therefore, "are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Id.* (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78, 115 S. Ct. 1223, 131 L. Ed. 2d 94 (1995)). But employers may vest health care benefits if they choose to do so. *Id.* at 400. When the plan document at issue is a collective bargaining agreement, the interpretative principles outlined in *Yard-Man* govern a court's determination

of the parties' intent to vest health-care benefits. *Maurer v. Joy Techs., Inc.*, 212 F.3d 907, 917 (6th Cir. 2000) (noting the continued application of *Yard-Man* to ERISA cases involving a collective bargaining agreement).[8]

The determination above that the parties intended health-care benefits to vest carries over to the ERISA § 502(a)(1)(B) claim. The Plaintiffs have therefore presented a plausible claim under ERISA § 502(a)(1)(B).

III.B.2.c. Sufficiency of Pleadings under ERISA 502(a)(3) Claim for Violation of Fiduciary Duties and Violation of Benefit Plan

ERISA § 502(a)(3) allows a plan "participant, beneficiary, or fiduciary" to bring a civil action:

> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

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[8] Defendant M & G points us to language in *Sprague* that it argues limits *Yard-Man's* application: "Because vesting of welfare plan benefits is not required by law, an employer's commitment to vest such benefits is not to be inferred lightly." *Sprague*, 133 F.3d at 400. Although the Defendant seems to contend that *Sprague* tacitly overruled the principles defined in *Yard-Man*, this Court has already rejected that argument. *See Maurer*, 212 F.3d at 917.

29 U.S.C. § 1132(a)(3). Section 502(a)(3) is a "catchall" for ERISA violations, *Varity Corp. v. Howe*, 516 U.S. 489, 511, 116 S. Ct. 1065, 134 L. Ed. 2d 130 (1996), that allows courts to provide "appropriate" equitable relief. 29 U.S.C. § 1132(a)(3). But § 502(a)(3) is not an appropriate means to relief when a plaintiff merely "repackage[s]" a § 502(a)(1)(B) claim: "Where Congress has elsewhere provided means to adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case [§ 502(a)(3)] relief normally would not be appropriate." *Varity*, 516 U.S. at 515, 116 S. Ct. 1065. In *Varity*, the Supreme Court allowed a plaintiff's fiduciary claims based on alleged employer misrepresentations to go forward when the plaintiff lacked a remedy under § 502(a)(1)(B). *Id.*

Although the *Varity* Court, in allowing the § 502(a)(3) claim, emphasized that the plaintiff could not have brought a § 502(a)(1)(B) claim, the Sixth Circuit sometimes allows a plaintiff to bring claims under both §§ 502(a)(3) and 502(a)(1)(B). *Hill v. Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 718 (6th Cir. 2005). The *Hill* Court allowed a plaintiff to bring claims under both sections when § 502(a)(1)(B) would not provide the complete relief the plaintiff sought. There the plaintiff complained of an "improper methodology for handling all of the * * * claims." *Hill*, 409 F.3d at 718. The Court held that the plaintiff had pleaded sufficient facts to support a § 502(a)(1)(B) for unpaid benefits.

But the plaintiff in *Hill* also brought a claim for injunctive relief under § 502(a)(3) to require the defendant "to alter the manner in which it administers all of the * * * claims." *Id.* The Court noted that this § 502(a)(3) claim was for "plan-wide injunctive relief, not [for] individual-benefit payments." *Id.* Although the plaintiff had the ability to seek damages for improperly denied benefits, the Court allowed the plaintiff to proceed on both claims because "[o]nly injunctive relief of the type available under § [502(a)(3)] will provide the complete relief sought." *Id.*

Relevant to a § 502(a)(3) claim, the Retiree Plaintiffs sought an injunction to prevent Defendant M & G from terminating their vested benefits in the future. Additionally, the Retiree Plaintiffs sought equitable relief to return them to their position before the Defendants' breach.[9] In appealing the district

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[9] In their Complaint, Plaintiffs said:

> Plaintiffs request that this Court[a]ward Class Members retiree health care benefits, pursuant to the terms of the applicable collective bargaining agreements and the Plans, and such monetary damages and/or equitable relief as necessary to restore Class Members to the positions in which they would have been and should be but for defendants' contractual and statutory violations and wrongful conduct.
>
> * * *
>
> Plaintiffs request that this Court[a]ward Class Members retiree health care benefits, pursuant to the terms of the applicable collective bargaining agreements and the Plans, and such monetary damages

(Continued on following page)

court's dismissal of their § 502(a)(3) claim, the Retiree Plaintiffs note that they claim "allegations of plan-wide breaches of fiduciary duty."

The mere recitation of the "plan-wide" language lifted from *Hill* will not justify a claim under § 502(a)(3) when § 502(a)(1)(B) relief is available. *Hill* involved an improper denial of benefits in the past and a current "improper methodology" for calculating benefits. 409 F.3d at 718. The Retiree Plaintiffs do not present an allegation of a flawed, systemic plan-wide methodology of calculating benefits.[10]

Instead, the Retiree Plaintiffs asked the district court for recovery of health benefits due under the plan (including monetary damages), a declaration of their rights to health benefits under the plan, and an injunction prohibiting the plan administrator from

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> and/or equitable relief as necessary to restore Class Members to the positions in which they would have been and should be but for defendants' contractual and statutory violations and wrongful conduct.

[10] *Hill* differs from this case in several other important ways. In *Hill*, five named plaintiffs brought a putative class action against a defendant ERISA plan administrator. This Court held that only one of the named plaintiffs could successfully bring an action under § 502(a)(1)(B) for money damages because the other four named plaintiffs had failed to exhaust their remedies. The Court said that futility would not excuse the failure to exhaust administrative remedies prior to bringing the § 502(a)(1)(B) claim. Additionally, the Court held that exhaustion was important because of the "fact-intensive" nature of the individual claims under § 502(a)(1)(B). *Hill*, 409 F.3d at 723.

modifying or terminating retiree health benefits in the future. All of these remedies are cognizable under § 502(a)(1)(B). *See Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147, 105 S. Ct. 3085, 87 L. Ed. 2d 96 (1985) (explaining that there are three distinct remedies available under § 502(a)(1)(B): "an action * * * [1] to recover accrued benefits, [2] to obtain a declaratory judgment that [a participant or beneficiary] is entitled to benefits under the provisions of the plan contracts, and [3] to enjoin the plan administrator from improperly refusing to pay benefits in the future"). The Retiree Plaintiffs' additional claims for equitable relief pursuant to § 502(a)(3) are simply repackaged claims for benefits. Because § 502(a)(1)(B) fully provides a means for the relief sought by the Retiree Plaintiffs, further equitable relief pursuant to § 502(a)(3) is unavailable. Accordingly, we affirm the district court's dismissal for the Retiree Plaintiffs' § 502(a)(3) claims for failure to state a claim under Rule 12(b)(6).

Before concluding, we also note that, in briefings before the district court, the Retiree Plaintiffs submitted extrinsic evidence alleging that the Defendants made misrepresentations about the Plan. The Retiree Plaintiffs proffered the declaration of a former Plant employee, Rodric R. Ball II, who retired in 1999 when M & G owned the plant. Ball stated that, during a 1998 meeting concerning retirement benefits, employees were "promise[d] * * * health coverage * * * at 'no cost.'" Declarant Ball provided a two-page document that reads under the heading MEDICAL:

"Continued coverage at no cost under the current P & I Agreement."

Because the Retiree Plaintiffs included none of the facts or allegations Ball described in their Amended Complaint, we decline to consider the declaration. We note, however, that the district court has discretion to permit a second amendment to the complaint "when justice so requires." FED. R. CIV. P. 15(a)(2).[11]

IV. Conclusion

We hold that the district court erred in treating a violation as a jurisdictional prerequisite and that it therefore erred in granting the Defendants' 12(b)(1) motion on the Plaintiffs' § 301 claim. We additionally hold that the district court erred in concluding that the Plaintiffs had failed to state a claim for relief in their Amended Complaint, thereby erring in granting the Defendants' 12(b)(6) motion on the § 301 and ERISA claims. Finally, we affirm the district court's

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[11] Without passing on the merit of a § 502(a)(3) claim incorporating Ball's Declaration, we note that the analysis presented above on duplicative relief would not apply to a § 502(a)(3) claim based on the misrepresentation if the district court eventually determines that the Retiree Plaintiffs did not have a vested right to health-care benefits. If the district court determines that the Retiree Plaintiffs did not have vested health-care benefits, the Retiree Plaintiffs, like the plaintiffs in *Varity*, would have "no 'benefits due [them] under the terms of [the] plan.'" *Varity*, 516 U.S. at 515, 116 S. Ct. 1065.

dismissal of the Plaintiffs' § 502(a)(3) claim. Accordingly, we **REVERSE** and **REMAND**.

523 F. Supp. 2d 684

Hobert Freel TACKETT, et al., Plaintiffs,
v.
M & G POLYMERS USA, LLC, et al., Defendants.

No. 2:07-cv-126.

United States District Court,
S.D. Ohio,
Eastern Division.

Nov. 21, 2007.

David Marvin Cook, Robert E. Rickey, Cook, Portune & Logothetis, Cincinnati, OH, Renate Klass, Stuart M. Israel, Martens, Ice, Klass, Legghio & Israel, P.C., Royal Oak, MI, for Plaintiffs.

Nelson D. Cary, Thomas Howard Fusonie, Vorys Sater Seymour & Pease, Columbus, OH, Christopher A. Weals, Morgan, Lewis & Bockius LLP, Washington, DC, Deborah S. Davidson, Philip A. Miscimarra, Morgan, Lewis & Bockius LLP, Chicago, IL, for Defendants.

OPINION AND ORDER

GREGORY L. FROST, District Judge.

This matter is before the Court for consideration of Defendants' motion to dismiss (Doc. # 19), Plaintiffs' memoranda in opposition (Docs. # 34, 35), Defendant's reply memorandum (Doc. # 36), and Plaintiff's sur-replies (Docs. # 61, 62). For the reasons that follow, the Court finds the motion to dismiss well taken.

I. Background

This is a class action case in which the putative class—retirees, their spouses, and surviving spouses or other dependents of individuals who worked for the named defendant company—assert that although they have a right to lifetime retiree health care benefits, the company is requiring them to pay for those benefits in violation of various collective bargaining agreement ("CBA") provisions. Plaintiffs Hobert Freel Tackett, Woodrow K. Pyles, and Harlan B. Conley are all Ohio residents and retirees from the Point Pleasant Polyester Plant in Apple Grove, West Virginia. They and similarly situated retirees belong to a labor union, Plaintiff United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC ("USW"), which represented (or at least one of its predecessor unions represented) them as employees of Defendant M & G Polymers USA, LLC ("M & G") (which bought the plant in 2000), or one of its predecessor companies, such as the Shell Chemical Company (which owned the plant from 1992 to 2000) and The Goodyear Tire & Rubber Company (which owned the plant until 1992). Plaintiffs assert that various CBA provisions provide lifetime retiree health care benefits.

Plaintiffs allege that on or about January 1, 2007, however, Defendant M & G unilaterally modified the health care benefits by shifting a large part of the health care costs onto the putative class members. The other named defendants are M & G-sponsored

health plans through which the putative class members receive health care benefits: the M & G Comprehensive Medical Benefits Program for Employees and Their Dependents, the M & G Catastrophic Medical Plan, the M & G Medical Necessity Benefits Program of Hospital, Surgical, Medical, and Prescription Drug Benefits for Employees and Their Dependents, and the M & G Major Medical Benefits Plan.

Plaintiffs filed the instant action on behalf of the named retirees and their surviving spouses or dependents, as well as other similarly situated retirees and their surviving spouses or dependents, on February 9, 2007. (Doc. # 1.) Via their amended complaint, Plaintiffs assert three counts: violation of labor agreements, actionable under Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185(a) (Count I); violation of employee welfare benefit plan, actionable under Sections 502(a)(1)(B) and (a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3) (Count II); and breach of fiduciary duty under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (Count III). (Doc. # 14 ¶¶ 26-31.)

On May 15, 2007, Defendants filed a motion to dismiss the amended class action complaint. (Doc. # 19.) In connection with that briefing, Plaintiffs filed a joint motion for leave to file two sur-reply memoranda (Doc. # 42), which the Court granted (Doc. # 60). The parties have therefore completed briefing on the motion to dismiss, which is now ripe for disposition.

II. Discussion

A. Standard Involved

Defendants move for dismissal under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). Rule 12(b)(1) provides that an action may be dismissed for lack of subject matter jurisdiction. Under the Federal Rules of Civil Procedure, "[p]laintiffs have the burden of proving jurisdiction in order to survive a Rule 12(b)(1) motion * * *." *Weaver v. Univ. of Cincinnati*, 758 F. Supp. 446, 448 (S.D. Ohio 1991) (citing *Moir v. Greater Cleveland Reg'l. Transit Auth.*, 895 F.2d 266, 269 (6th Cir. 1990)). *See also Rapier v. Union City Non-Ferrous, Inc.*, 197 F. Supp. 2d 1008, 1012 (S.D. Ohio 2002) (citing *McNutt v. General Motors Acceptance Corporation of Indiana, Inc.*, 298 U.S. 178, 189, 56 S. Ct. 780, 80 L. Ed. 1135 (1936); *Rogers v. Stratton Indus., Inc.*, 798 F.2d 913, 915 (6th Cir. 1986)) ("The plaintiff bears the burden of establishing, by a preponderance of the evidence, the existence of federal subject matter jurisdiction"). Moreover, this Court may resolve any factual disputes when adjudicating a defendant's jurisdictional challenge. *See Moir*, 895 F.2d at 269.

In contrast to Rule 12(b)(1), Rule 12(b)(6) requires an assessment of whether Plaintiffs have set forth claims upon which this Court may grant relief. For the purpose of the analysis under Rule 12(b)(6), this Court must construe the amended complaint in favor of Plaintiffs, accept the factual allegations contained in the amended complaint as true, and

determine whether Plaintiffs' allegations plausibly suggest viable claims. *See NicSand, Inc. v. 3M Co.*, 507 F.3d 442, 448 (6th Cir. 2007); *Assoc. of Cleveland Fire Fighters v. City of Cleveland, Ohio*, 502 F.3d 545, 548 (6th Cir. 2007); *cf Goad v. Mitchell*, 297 F.3d 497, 500 (6th Cir. 2002). In other words, "a complaint will be dismissed pursuant to Rule 12(b)(6) only if there is no law to support the claims made, or if the facts alleged are insufficient to state a claim, or if on the face of the complaint there is an insurmountable bar to relief." *The Limited, Inc. v. PDQ Transit, Inc.*, 160 F. Supp. 2d 842, 843 (S.D. Ohio 2001) (citing *Rauch v. Day & Night Mfg. Corp.*, 576 F.2d 697, 702 (6th Cir. 1978)).

B. Analysis

Relying on Rule 12(b)(1), Defendants first argue that the Court should dismiss Plaintiffs' § 301 claim constituting Count I because the claim fails to present a breach of the CBA. Rather, Defendants assert, they have simply complied with the CBA and ancillary agreement provisions that permit the implementation of above-cap contributions. Defendants then argue that dismissal is also warranted under Rule 12(b)(1) because the National Labor Relations Board ("NLRB") has primary jurisdiction over the claim, with the caps constituting an agreed-upon mandatory subject of bargaining. Finally, Defendants posit that dismissal is warranted under Rule 12(b)(6) because the limitations on the health benefits, including caps on employer contributions, were the result of collective

bargaining and disclosed in the 1991 summary plan description.

The nature of Defendants' initial challenge to this Court's jurisdiction over Count I means that the Court can look outside the factual allegations of the pleadings. Were this a facial attack on the amended complaint under Rule 12(b)(1), the Court would necessarily accept the factual allegations of the amended complaint as true. *See U.S. v. A.D. Roe Co., Inc.*, 186 F.3d 717, 721-22 (6th Cir. 1999) (explaining that in "a facial attack on subject matter jurisdiction, [a court] would take the allegations in the complaint as true and construe them in the light most favorable to the non-moving party"); *see also RMI Titanium Co. v. Westinghouse Electric Corp.*, 78 F.3d 1125, 1134 (6th Cir. 1996). In the absence of a facial attack on the amended complaint, however, this Court need not accept that pleading's factual allegations as true. *See RMI Titanium Co.*, 78 F.3d at 1134 (explaining that when a Rule 12(b)(1) motion attacks the existence of subject matter jurisdiction, apart from the pleadings, a court does not accept the pleadings as true but weighs the evidence as needed to determine jurisdiction); *Wright v. United States*, 82 F.3d 419, 1996 WL 172119, at *4 (6th Cir. 1996) (unpublished table decision) ("Regardless of what the complaint says, the court has no subject matter jurisdiction if the factual predicates of subject matter jurisdiction do not exist."). Thus, the Court can consider evidence extrinsic to the pleadings without converting the matter into a summary judgment proceeding. *See* FED. R. CIV. P.

10(c) ("A copy of any written instrument which is an exhibit to a pleading is a part thereof for all purposes."); *Nichols*, 318 F.3d at 677; *Rogers v. Stratton Industries, Inc.*, 798 F.2d 913, 915-16 (6th Cir. 1986) (supplementation of record in Rule 12(b)(1) challenge does not convert motion to dismiss into a summary judgment motion).

Consideration of such evidence—which has been properly authenticated—defeats Plaintiffs' position.[1] Defendants argue that Letter of Understanding 2003-6, dated August 9, 2005, and made part of the current CBA (which controls the period from August 9, 2005 through November 6, 2008), permits implementation of above-cap contributions. (Doc. # 19-9, Ex. 8, at 6-7.) This letter indeed contemplates caps on employer contributions to retiree health benefits and provides that "premium cost sharing charged to retirees will be based in the amount by which total cost for all retiree insurances (medical, life, etc.) exceed the caps set forth in Letter H dated January 1, 2001." (Doc. # 19-9, Ex. 8, at 6.) The letter continues to state that retirees would not be required to contribute to their premiums until January 1, 2006, and that the retiree

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[1] The Court assumes for the sake of argument that a Rule 12(b)(1) inquiry is appropriate here. *See Gentek Bldg. Prods., Inc.* v. *Steel Peel Litigation Trust*, 491 F.3d 320, 330 (6th Cir. 2007) (reasoning that when a factual attack on jurisdiction implicates an element of the cause of action, a district court should conclude that jurisdiction exists and proceed to address a direct attack on the merits of the plaintiff's claim.).

premium contribution rates would become effective on that date. (Doc. # 19-9, Ex. 8, at 6.)

Defendants additionally direct this Court to a May 15, 1991 letter ("Letter G") incorporated into the CBA effective May 15, 1991. Letter G provides both that a specific age-based cap limitation exists on the employer contributions for each employee who retires on or after May 1, 1991, and that "[i]f the average annual cost of health care benefits for [each group of retirees outlined in the letter] exceeds the specified amount, the cost in excess of that amount shall be allocated evenly to all retired employees (including surviving spouses) in such group." (Doc. # 19-3, Ex. 2, at 8.) The letter, signed by a representative of each side, then provides that "no retired employee or surviving spouse shall be obligated to contribute for such excess health care cost until July 1, 1997." (Doc. # 19-3, Ex. 2, at 8.)

Plaintiffs attack Defendants' reliance on this authenticated letter and similar documents—cap letters dated July 20, 1994, May 9, 1997, and January 1, 2001 (Docs. # 19-3, 19-4, 19-5)—on the grounds that they all relate to *Goodyear* retirees and that Defendants have failed to show that the *Goodyear* documents apply to Shell and M & G employees who retired from the Apple Grove plant after it was sold by Goodyear to Shell in 1992, and then sold by Shell to M & G in 2000. In fact, in its sur-reply, Plaintiff USW even states that "M & G argues that Shell's assumption of the Goodyear CBA and P & I agreement necessarily included the 1991 Goodyear 'cap'

letter, but presents *no evidence* in support of that argument." (Doc. # 61, at 4 n.2.)

The Court has struggled with Plaintiffs' premise because it is so curious that the Court has been concerned that it is not reading Plaintiffs' briefing correctly. There is ultimately no doubt, however, that Plaintiffs are attempting in this specific context to evade the very agreements into which they voluntarily entered. There is also no doubt that, in contrast to Plaintiffs' contention, Defendants have presented ample evidence supporting application of the cap letters.

The first cap letter originated in 1991. The declaration of James Kruse, the retired Goodyear employee responsible for human resources and labor relations (including collective bargaining over retiree benefits), indicates that the May 15, 1991 Letter G was part of the agreement incorporated into the Master P & I Agreement and that it applied to the Apple Grove plant. The declaration also explains that Shell assumed the agreement obligations as a successor as part of its 1992 purchase of the plant. (Doc. # 37, Ex. 12.)

The declaration of Dale Wunder, Shell's Vice President of Human Resources who was assigned to the Apple Grove plant, also indicates that Shell assumed the existing agreement obligations as a successor. Wunder additionally indicates that although the parties agreed not to change the agreements from using "Goodyear" to using "Shell," the

parties agreed that the 1994 and 1997 Goodyear agreements were applicable to the Apple Grove plant. Notably, Wunder also indicates that Shell and the union specifically agreed that the July 20, 1994 Letter G to the 1994 P & I Agreement and the May 9, 1997 Letter H to the 1997 P & I Agreement applied to retirees from the Apple Grove plant. (Doc. # 37, Ex. 13.) Thus, the caps remained applicable.

In 2000, Shell sold the Apple Grove plant to M & G. The declaration of Kimm Korber, M & G's Human Resources Director, indicates that M & G assumed the preexisting CBA and its obligations as a successor to Shell, that the union asserted in negotiations that the January 1, 2001 Letter H applied, and that the eventual 2005-08 CBA included the Letter of Understanding 2003-6 that tracks and reaffirms the caps applicable to all preexisting retirees back to the original May 15, 1991 Letter G. Moreover, the declaration specifically states that the union never disputed that the retiree contributions could be collected in the form of monthly contributions. (Doc. # 37, Ex. 14.)

These declarations and their attachments thus present an unbroken chain of cap letter applicability. Plaintiffs, overlooking the union's assertion during negotiations with M & G that the 2001 cap-supporting Letter H applied, argue that M & G admitted the caps did not apply. The declaration of David Dick, an attorney who represented M & G in the 2000 negotiations, clarifies that M & G's October 17, 2000 communication denying applicability of the

1994 and 1997 letters was the result of a lack of understanding on his part of the history of cap incorporation and that the denial did not modify the existing agreements and party obligations. (Doc. # 37, Ex, 15.)

The text of Letter of Understanding 2003-6 unambiguously supports the unbroken application of caps to retirees (including preexisting retirees). That document explicitly references the prior 2001 cap letter and provides that "[r]etiree benefits" means "benefits for the Company's preexisting retirees." (Doc. # 19-9, at 6.)

In contrast to this evidence of continued application of the caps, Plaintiffs present an argument based on inferences, selectively pointing to documents such as M & G's October 17, 2000 negotiation memorandum, while sidestepping the evidence that placed that document in context and evidence that the caps have long and continuously applied. Four additional points warrant fuller discussion.

First, Plaintiffs have unsuccessfully attempted to change the context of the argument. As previously noted, Defendants' Rule 12(b)(1) motion to dismiss is a factual, not facial, challenge to jurisdiction. Defendants in fact sought to emphasize this point, stating in the memorandum in support of their motion the applicable standard and scope of review for "[w]here, as here, a party factually challenges a court's jurisdiction to hear a claim * * * * *" (Doc. # 19, at 10 n.5.) But in an effort to defeat judicial

consideration of the substance of Defendants' declarations, Plaintiffs attempt to recast the nature of the Rule 12(b)(1) attack as a facial attack on the amended complaint. *See* Doc. # 61, at 5 (Plaintiff USW argues that "alleged conversations cannot support a Rule 12(b)(1) or (6) motion, which is based on the assertion that the complaint fails to state a claim and that the Court lacks jurisdiction."); Doc. # 62, at 1 ("Plaintiff Retirees adopt the arguments set forth in Plaintiff USW's surreply regarding Plaintiffs' LMRA Section 301 claims."). Because Defendants assert a factual, not facial, attack, the Court can consider and even weigh the substance of the declarations in the Rule 12(b)(1) context, without proceeding to Rule 12(b)(6) and a subsequent conversion to a Rule 56 proceeding. *See DLX, Inc. v. Kentucky*, 381 F.3d 511, 516 (6th Cir. 2004) ("A Rule 12(b)(1) motion * * * can attack the factual basis for jurisdiction, in which case the trial court must weigh the evidence and the plaintiff bears the burden of proving that jurisdiction exists.").

Second, the October 17, 2000 M & G memorandum (itself extrinsic evidence) cannot trump the parties' agreement reached after that (ill-informed) negotiating position; the subsequent agreement reached by the parties reaffirmed the applicability of the caps. Thus, there is no modification as Plaintiffs assert, but only a validation of the preexisting cap agreements and obligations.

Third, the M & G purchase agreement for the Apple Grove plant fails to defeat the applicability of the cap letters. Even if the purchase agreement

excluded the cap letter obligations, this does not speak to the pre-purchase obligations of the pre-2000 retirees or the pre-purchase application of caps. And even if the purchase agreement did not include the cap provisions, the parties' subsequent dealings as outlined in the negotiations reaffirmed the application of the caps to preexisting and subsequent retirees. In other words, there *might* have been an argument that M & G meant to exclude these benefit obligations via the purchase agreement, but the union and the company then reaffirmed the cap and benefit obligations so as to defeat the continued vitality of that argument.

Fourth, the premise of Plaintiffs' claim, that termination of benefits for retirees who fail to contribute, similarly fails because termination does not present a breach. For the period of time at issue, there are no guaranteed benefits absent retiree contributions. This means the asserted terminations do not breach the CBAs.

The end result is that Plaintiffs have failed to meet their burden of proving that jurisdiction exists. Count I of the amended complaint targets "specified lifetime health care benefits," and the specified benefits include sharing costs. The retirees are entitled to an employer contribution toward health benefits, but they must pay premium contributions; there is simply no contractual right to contribution-free health benefits, even if agreements have long deferred the eventual collection of the retirees'

shares. The company's right to terminate benefits for retirees' failure to contribute is implicit.

Therefore, the evidence before this Court indicates that because the caps scheme has continued to apply, Defendants are correct in asserting that there is no breach of the CBA. Absent a breach by Defendants, this Court lacks jurisdiction over the § 301 claim constituting Count I of the amended complaint. *See United Gov't Sec. Officers of Am. v. Akal Sec., Inc.*, 475 F. Supp. 2d 732, (S.D. Ohio 2006) (holding that there is no viable § 301 claim where there is no breach of a CBA); *cf. Bauer v. RBX Indus., Inc.*, 368 F.3d 569, 578 (6th Cir. 2004) ("Jurisdiction in a § 301 claim is premised upon the existence of a contract, which an employer subsequently breaches. Section 301 opens the federal courthouse only to '[s]uits for violation of contracts.'" (quoting 29 U.S.C. § 185(a))).

But even assuming that the Court should indeed presume jurisdiction and proceed under Rule 12(b)(6) as Plaintiffs suggest, dismissal is still warranted. Because much of this analysis in regard to the Rule 12(b)(6) attack on the Count I § 301 claim involves the same analysis related to Plaintiffs' ERISA claims in Counts II and III, the Court shall proceed to discuss the Rule 12(b)(6) inquiry together.

Defendants move for dismissal of these counts pursuant to Rule 12(b)(6), for failure to state a claim upon which this Court can grant relief. Defendants argue that the Court cannot grant relief on Count I because there is no breach, given that retirees have

no right to lifetime health benefits without mandated retiree contributions. Defendants then posit that dismissal of the ERISA Section 502(a)(1)(B) component of Count II is warranted because the incorporated letters referenced above provide that the issue of retiree health benefits is a mandatory subject of bargaining, which indicates that the retirees' health benefits were and are not vested as lifetime benefits as Plaintiffs contend. Defendants' rationale here is that because 29 U.S.C. § 1132(a)(1)(B) only permits a plan participant "to recover benefits due to him under the terms of his plan," the retirees cannot proceed under this ERISA provision because the parties' [sic] agreed only to retiree medical benefits contingent on retiree contributions. Thus, Defendants reason, in the absence of a retiree contribution, there is no right to an employer contribution. The analysis is that no retiree contribution equals no benefit due, which means there is no due benefit to recover under § 1132(a)(1)(B).

Defendants also seek a Rule 12(b)(6) dismissal of the ERISA Section 502(a)(3) component of Count II and the entirety of Count III essentially on the grounds that the section is unavailable because ERISA Section 502(a)(1)(B) already provides a remedy. Plaintiffs argue that this is an incorrect construction of both ERISA and their amended complaint and that there have been actionable fiduciary misrepresentations.

A medical benefit plan is a type of welfare benefit plan, which means that it is not subject to automatic

or mandatory vesting under ERISA, but can be vested by agreement of the parties. *Bauer*, 368 F.3d at 584. What proves unusual in this case is that the context of this Rule 12(b)(6) aspect of the motion to dismiss precludes this Court from considering the letter agreements of the parties here, even if the Court could and did consider this material in regard to the dismissal of Count I.

In addressing above the motion to dismiss Count I, this Court conducted a Rule 12(b)(1) factual inquiry that permitted and necessitated review of extrinsic evidence (i.e., Defendants' declarations, which presented the cap letters as applicable to the dispute). As Plaintiffs correctly note in their briefing, however, a Rule 12(b)(6) inquiry mandates a different approach. Under Rule 12(b)(6), the Court cannot engage in such a factual inquiry, but must accept the factual allegations contained in Plaintiffs' amended complaint as true and then decide whether these facts present a plausible claim to relief. Plaintiffs assert that the Rule 12(b)(6) inquiry means that the Court must necessarily accept that the plan documents and CBAs confer lifetime health care benefits on the retirees and that the plans and CBAs preclude termination by Defendants. Thus, Plaintiffs conclude, the pleading presents a potentially viable claim under Counts I and II.

Defendants indeed attack Counts I and II by relying on the letter agreements, which as discussed above rely on the declarations for validation. Although the Court can consider documents referenced

in the amended complaint, the pleading generally makes vague references to the parties' agreements without specifying what constitutes the bulk of the agreements; it is only through the extrinsic evidence that the Court was persuaded above that the letters mattered. Defendants also rely on summary plan descriptions, which do not grow out of the pleading but are extrinsic to the amended complaint. To consider this material, the Court would have to convert the Rule 12(b)(6) motion to dismiss into a Rule 56 motion for summary judgment.

> Rule 12 permits such conversion, stating:
>
> > If, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

FED. R. CIV. P. 12(b). What this means is that generally a court must provide the parties notice of its intent to convert, although under various circumstances notice is not always required. *See Cunningham v. Osram Sylvania, Inc.*, 221 F. App'x 420 (6th Cir. 2007) (concession of both parties in Rule 12(b)(6) briefing that conversion is appropriate negates need for notice of intent to convert).

Weighing against conversion and consequent consideration of Defendants' extrinsic materials is the fact that Plaintiffs have raised a demand to conduct discovery on the alleged fiduciary misrepresentations. (Doc. # 62, at 3 ("Plaintiffs are entitled, at a minimum, to conduct discovery on this claim.").) The Court in its discretion therefore declines to consider material extrinsic to the pleadings in regard to the motion to dismiss Counts I through III, which means that conversion is not necessary. Proceeding to address the motion within the confines of a Rule 12(b)(6) inquiry, then, the Court nonetheless concludes that dismissal is warranted.

The aforementioned *Cunningham v. Osram Sylvania, Inc.* notably informs this conclusion. In *Cunningham*, the Sixth Circuit described the relevant facts of that similar § 301 case as follows:

> The plaintiffs are former Sylvania employees who retired in 1998 and 2002. They brought this action on the theory that Sylvania's announcement in 2003 that its contribution to their medical insurance premiums would henceforth be "capped" at scheduled amounts constituted a unilateral modification of non-modifiable lifetime benefits granted to retirees under union contracts between their union, UAW Local 1608, and Sylvania. The company's action came in the wake of provisions in collective bargaining agreements dating back to 1993, the year that Sylvania purchased the Kentucky facility where the plaintiffs were employed. After

> Sylvania took over the plant, the health insurance benefits for retirees fell into two categories, based on age and length of service. The first category covered those employees who were under the age of 45 on the date of purchase and who were eligible to receive a percentage of the premium at company expense, based on their years of employment and capped at a certain amount set out in a separate schedule. Those over the age of 45 on the purchase date were subject to the same eligibility formulas, but the amounts to which they were entitled were not capped. As medical insurance costs began to rise precipitously in the decade following Sylvania's takeover of the plant, however, the company negotiated minor changes in the collective bargaining agreements with the UAW and, outside the contract, made certain other changes in the retirees' health insurance coverage. Finally, in 2003, after failing to secure a change in the most recent contract, the company notified retirees that the distinction between the capped and uncapped premiums had been removed from the plan and that, henceforth, all health insurance premiums would be subject to a cap on amounts paid by the company. In response, the plaintiffs brought suit, alleging that this unilateral change in benefits was in violation of the LMRA.

221 F. App'x. at 421-22. This description of retirement benefit scheme based on age and length of service roughly tracks the scheme in the instant case.

The *Cunningham* scheme provided that retirees over 45 with sufficient years of employment were entitled to receive uncapped company contributions to their health benefit premiums. This echoes the amended pleading's assertion in the instant case that retirees with "95 or more points 'will receive a full Company contribution towards the cost of benefits described in Exhibit B-1.'" (Doc. # 14 ¶ 14.)

To support this assertion, Plaintiffs' amended complaint cites an excerpted copy of the 2000 Pension, Insurance and Service Award Agreement "attached here as 'Exhibit A.'" (Doc. # 14 ¶ 14.) But no such exhibit is attached to the amended complaint. The original complaint (Doc. # 1) did, however, include the exhibit. Assuming arguendo that this Court can consider the original complaint's attachment when construing the assertions of the amended complaint, the Court must conclude that dismissal is warranted.

The Sixth Circuit explained in *Cunningham* that the complaint in that case

> omitted any facts to support the bald conclusions that "[t]he insurance benefits conferred on all retirees by the Agreements are lifetime benefits to which plaintiffs and other retirees from the Winchester, Kentucky plant are entitled for the remainder of their lives" and that those benefits "cannot be unilaterally modified or terminated by the defendant without the consent of the retirees."

221 F. App'x at 422. The court of appeals therefore concluded that "[b]ecause this proposition was pleaded without factual support of any kind, in our judgment the district court could have entered an order of dismissal for failure to state a claim under Rule 12(b)(6)."[2] *Id.*

The amended complaint *sub judice* similarly asserts that "[u]nder the terms of the applicable collective bargaining agreements, [each named retiree (and in some instances his spouse)] are entitled to lifetime health care benefits, which defendants are obligated to provide." (Doc. # 14 ¶¶ 9, 10, 11.) The amended pleading similarly asserts that class members

> became vested in retiree health care benefits and became entitled to receive lifetime health care benefits, and their spouses and surviving spouses became vested and entitled to receive health care benefits for life or until remarriage, as were the surviving spouses of certain employees who died while employed at the Plant.

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[2] Because the district court under review in *Cunningham* had instead elected to consider extrinsic evidence, the court of appeals proceeded to treat the district court's disposition of the motion to dismiss under a Rule 56 inquiry. 221 F. App'x at 422-24. This Court has declined to consider extrinsic material in regard to the Rule 12(b)(6) aspect of Defendants' motion to dismiss.

(Doc. # 14 ¶ 15.) Finally, echoing the language in *Cunningham*, the amended complaint concludes that "defendants violated these rights by shifting a large part of the costs of those benefits from defendants to Class Members, and have terminated or planned to terminate the benefits of those Class Members unable to pay or who otherwise do not pay the added costs imposed by defendants." (Doc. # 14 ¶ 16.)

This Court concludes that, as in *Cunningham*, because Plaintiffs have plead propositions without factual support of any kind, dismissal under Rule 12(b)(6) is warranted. Plaintiffs amended complaint quotes paragraph 11 of the agreement constituting Exhibit A. Review of that agreement indicates that it does indeed state that qualifying retirees "will receive a full Company contribution towards the cost of the benefits described in this Exhibit B-1 * * * * *" (Doc. # 1-2, at 3 ¶ 11.) But many of the conclusions Plaintiffs draw from that statement exceed factual allegations that this Court must accept as true in the Rule 12(b)(6) context. Instead, Plaintiffs assert unsupported contentions including legal conclusions.

The relevant agreement paragraph does not present vesting or preclude monthly retiree premiums and the termination of benefits for failure to pay those premiums. To reach that conclusion would be to ignore both the language employed in the quoted sentence and other sentences in that paragraph that Plaintiffs have elected not to quote in their pleading.

Applying simple principles of contract construction to the key sentence upon which Plaintiffs rely—"Employees * * * will receive a full Company contribution towards the cost of the benefits described in this Exhibit B-1 * * * * *" (Doc. # 1-2, at 3 ¶ 11)—the Court must recognize that "full" modifies "Company contribution" in the quoted sentence, not "cost." What the sentence therefore says is that qualifying retirees will receive the total amount of the company's *potential* contribution toward the cost of health benefits, not that the company will cover the full cost of the benefits if the benefits exceed the total potential (i.e., capped) contribution. "[A] full Company contribution" is consistent with caps.

This construction distinguishes the agreement language at issue here from those cases to which Plaintiffs direct this Court as containing "virtually identical CBA language [that] has been held to constitute a lifetime promise of retiree medical benefits" (Doc. # 61 at 3 n.1) For example, the language creating vested lifetime benefits in *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW v. Loral Corp.*, read as follows: "Employees who retire and who are eligible under the Loral Systems Group Retirement Plan for Bargaining Unit Employees for a pension (other than a deferred vested pension), shall receive the benefits described in this Section B * * * * *" 873 F. Supp. 57, 63 (N.D. Ohio 1994), *aff'd*, 107 F.3d 11, 1997 WL 49077, at *2 (6th Cir. 1997) (unpublished table decision). The distinction is obvious: that case's

"shall receive the benefits" contrasts significantly with the instant case's "will receive a full Company contribution towards the costs of the benefits." The former promises benefits, while the latter promises a contribution that context places within a contingent retiree-contribution scheme; there is no guarantee here that the employer contribution is either unqualified or sufficient to cover the cost of benefits.[3] The agreement in the case *sub judice* distinguishes this case from those in which a presumption of lifetime benefits—which the Sixth Circuit has described as the "*Yard-Man* inference"—proves correct. *See Loral Corp.*, 1997 WL 49077, at *2.

Additionally, Plaintiffs neglect that the referenced agreement paragraph also states that "[e]mployees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the benefits described in this Exhibit B-1. Failure to pay the required medical contribution will result in cancellation of coverage." (Doc. # 1-2, at 3 ¶ 11.) The language of the paragraph in no way restricts the reference to "Employees" to mean only those retirees with less than the 95 qualifying points, which means that the agreement

---

[3] This same rationale distinguishes the lifetime-benefits case of *United Rubber, Cork, Linoleum & Plastic Workers of America, AFL-CIO, CLC v. Pirelli Armstrong Tire Corp.*, in which the documentation at issue provided that medical benefits "will be provided" without a termination provision, as opposed to a simple employer contribution scheme. 873 F. Supp. 1093, 1098 (M.D. Tenn. 1994).

paragraph contradicts the amended pleading's assertions of vesting of lifetime non-contingent benefits and that Defendants cannot require retiree contributions and terminate benefits for a failure to make such contributions. It is beyond question that the agreement also permits termination for retirees with less than 95 points who fail to make their contributions.

The apparent inferences Plaintiffs (explicitly or implicitly) ask this Court to draw are unreasonable and unwarranted in light of the foregoing language. There is thus no support for Plaintiffs' allegations behind the Count I § 301 claim or the Count II claim to enforce rights and enjoin plan violations.[4] There is also no support for lifetime benefits that cannot be terminated. The attachment exhibit in fact contravenes Plaintiffs' pleading in this regard, undercutting the plausibility of their claim to relief.

This leaves Count III. That count asserts a breach of fiduciary duty under ERISA, alleging according to Plaintiffs' own characterization that Defendants "breached their fiduciary duties by not administering the plans in a prudent manner, by failing to act for the exclusive purpose of providing benefits, and by wrongfully burdening participants and beneficiaries of the plans with monthly 'premiums,'

---

[4] The lack of a foundation for an ERISA violation renders Defendants' arguments as to redundant sources of relief under the various ERISA provisions moot.

causing hardship to the retirees and, in many instances, termination of health benefits." (Doc. # 62, at 3 (tracking Amended Complaint, Doc. # 14 ¶ 34).) Even assuming arguendo that this is a viable cause of action under ERISA, Plaintiffs have failed to plead facts supporting imprudent conduct and a failure to act for the plan purpose. Moreover, as described above, Plaintiffs have failed to plead facts supporting the wrongful imposition of retiree contributions.

The Court notes that the briefing includes Plaintiffs' assertion that Count III also targets the specific allegation that Defendants misled prospective retirees with promises that they would receive "no cost" health benefits during their retirement. *See, e.g.*, Doc. # 62, at 3. It is important to note, however, that *nowhere in the amended complaint* do Plaintiffs plead this allegation or how or what Defendants purportedly did in this regard, beyond a reference in Count I that the CBAs promised retirees health benefits. It is a wholly unsupported factual contention derived from the briefing, and this Court is restricted under Rule 12(b)(6) to crediting the amended pleading, not briefing. Accordingly, Plaintiffs' belated contention is not sufficient to present a viable Count III upon which this Court could grant relief.

In summary, in addition to the 12(b)(1) attack on Count I, Plaintiffs' amended complaint also does not include "enough factual matter (taken as true) to suggest that" there is a foundation for Counts I, II, and III plausibly suggesting a right to relief. *Bell Atlantic Corp. v. Twombly*, ___ U.S. ___, ___, 127 S. Ct.

1955, 1965, 167 L. Ed. 2d 929 (2007). Because the pleading's factual allegations are not "enough to raise a right to relief above the speculative level," *see id.*, the Court must dismiss the complaint under Rule 12(b)(6).[5]

III. Conclusion

For the foregoing reasons, the Court GRANTS Defendant's motion to dismiss. (Doc. # 19.) The Court therefore need not address Plaintiffs' moot motion for a preliminary injunction (Doc. # 40) and Defendants' moot motion to strike the jury demand (Doc. # 20).

The Clerk shall enter judgment accordingly and terminate this case upon the docket records of the United States District Court for the Southern District of Ohio, Eastern Division, at Columbus.

IT IS SO ORDERED.

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[5] The Court therefore need not and does not address Defendants' moot alternative "preemption" ground for dismissal of Count I under Rule 12(b)(1).

Nos. 12-3329/3407

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

HOBERT FREEL TACKETT, ET AL., Plaintiffs-Appellees, v. M&G POLYMERS USA, LLC, ET AL., Defendants-Appellants.	)	ORDER (Filed Oct. 22, 2013)

BEFORE: KEITH and COLE, Circuit Judges.*

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original

* Hon. Boyce F. Martin, Jr., who was a member of the panel rendering a decision in this appeal, retired on August 16, 2013.

submission and decision of the cases. Accordingly, the petition is denied.

ENTERED BY ORDER
OF THE COURT

/s/ Deborah S. Hunt
Deborah S. Hunt, Clerk

29 U.S.C. § 185

(a) Venue, amount, and citizenship

Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties.

(b) Responsibility for acts of agent; entity for purposes of suit; enforcement of money judgments

Any labor organization which represents employees in an industry affecting commerce as defined in this chapter and any employer whose activities affect commerce as defined in this chapter shall be bound by the acts of its agents. Any such labor organization may sue or be sued as an entity and in behalf of the employees whom it represents in the courts of the United States. Any money judgment against a labor organization in a district court of the United States shall be enforceable only against the organization as an entity and against its assets, and shall not be enforceable against any individual member or his assets.

(c) Jurisdiction

For the purposes of actions and proceedings by or against labor organizations in the district courts of the United States, district courts shall be deemed to

have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in representing or acting for employee members.

(d) Service of process

The service of summons, subpoena, or other legal process of any court of the United States upon an officer or agent of a labor organization, in his capacity as such, shall constitute service upon the labor organization.

(e) Determination of question of agency

For the purposes of this section, in determining whether any person is acting as an "agent" of another person so as to make such other person responsible for his acts, the question of whether the specific acts performed were actually authorized or subsequently ratified shall not be controlling.

29 U.S.C. § 1132(a)(1)(B)

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the

terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

OPPOSITION BRIEF

RECORD
\ AND 1
BRIEFS

Supreme Court, U.S.
FILED
MAR 2 6 2014
OFFICE OF THE CLERK

No. 13-1010

In the Supreme Court of the United States

M&G POLYMERS USA, LLC, *et al.*,
Petitioners,

v.

HOBERT FREEL TACKETT, *et al.*,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF IN OPPOSITION

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

In this LMRA/ERISA CBA-breach and enforcement action brought by retirees, spouses, and the retirees' labor union against the successor, M&G, to the retirees' former employer,

where the Sixth Circuit and the District Court held that contractually promised benefits were vested following a trial on the merits,

WHETHER this Court should decline review of the Sixth Circuit decision enforcing those contractual promises because:

1. The Sixth Circuit applied traditional contract interpretation rules to a fact-specific CBA dispute which is of interest only to the litigants and is grounded on a trial record that contained no error, and

2. with minor variations in approach, all circuits hold that LMRA/ERISA cases are governed by traditional contract interpretation rules applied to particular circumstances, and

3. the Sixth Circuit decision does not address any "important federal question" or depart from the "accepted and usual course of judicial proceedings;" is not in conflict with any legal question decided by this Court or any other circuits; does not call for the exercise of this Court's supervisory power; and otherwise does not present any question warranting this Court's review.

PARTIES TO THE PROCEEDING

Respondents are retirees Hobert Freel Tackett, Woodrow W. Pyles, and Harlan B. Conley, on behalf of themselves and all other similarly situated persons in the Class (consisting of nearly 500 people who retired from M&G or one of its predecessors, Goodyear or Shell Chemical, and the retirees' eligible family members), and Plaintiff United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC ("USW").

Except where distinctions are necessary, we refer to all respondents as **"plaintiffs"** and to the retirees and spouses collectively as **"retirees."** We refer to USW and its predecessors as the **"union."**

TABLE OF CONTENTS

COUNTERSTATEMENT OF QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDING ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES vi

INTRODUCTION AND SUMMARY OF ARGUMENT 1

COUNTERSTATEMENT OF THE CASE 3

District Court Decisions At Issue 4

A. The Liability Decision 4

B. The Injunction Decision 5

ARGUMENT 6

I. M&G's Arguments For Certiorari Lack Merit. 6

A. The Sixth Circuit Does Not Apply Presumptions In LMRA/ERISA Retirement Healthcare Cases 6

1. An Inference And A Presumption Are Not Equivalent. 6

2. The Vesting Language Present Here Has Long Been Acknowledged To Solidify Lifetime, Vested Healthcare Benefits. 8

3. The Enforcement Of Contractual Promises Results In No Detriment . 9

4. The Sixth Circuit Has Repeatedly Rejected A Presumption In Favor Of Vesting 10

B. The Case Is Determined By "Traditional Rules Of Contract Interpretation" And The "Overwhelming" Evidence. 13

C. There Is No "Irreconcilable" Conflict Or Legal Inconsistency Between The Sixth Circuit And Other Circuits, All Of Which Apply Traditional Contract Interpretation Rules To Fact-Specific Circumstances To Resolve Retirement Healthcare Disputes. 14

1. This Court Has Repeatedly Rejected Certiorari In These Garden-Variety Contract Interpretation Cases. 14

2. All Circuits Employ Similar Methods When Determining LMRA/ERISA Matters 15

3. Decisions Cited By M&G Point Out That Traditional Rules Of Contract Interpretation Apply 17

4. Minor Differences In Approach Between Circuits Are Not Conflicts 19

II. Both Contractually Bargained Benefits And Standard ERISA Plans Are Determined According To Standard Rules Of Contractual Interpretation, But The Context For Interpretation Is Markedly Different 21

III. Regardless Of The Legal Standards Applied, M&G Cannot Overcome The Substantial Findings Of Fact Which Undermine Its Case, And Therefore M&G's Petition For Certiorari Is Futile 22

CONCLUSION 23

APPENDIX

Appendix 1 Opinion and Order in the United States District Court Southern District of Ohio Eastern Division (August 5, 2011) ..... App. 1

TABLE OF AUTHORITIES

CASES

AT&T Mobility LLC v. Concepcion,
131 S. Ct. 1740 (2011) 2

Anderson v. Alpha Portland Industries, Inc.,
836 F.2d 1512 (8th Cir. 1988), *cert. denied* 489
U.S. 1051 (8th Cir. 1989) 15, 16

Bender v. Newell Window Furnishings, Inc.,
681 F.3d 253 (6th Cir. 2012), *cert denied* 133 S.
Ct. 436 (2012) 7, 11, 12, 14

Bidlack v. Wheelabrator Corp.,
993 F.2d 603 (7th Cir. 1993), *cert. denied* 510
U.S. 909 (1993) 15, 16

Cherry v. Auburn Gear, Inc.,
441 F.3d 476 (7th Cir. 2006) 15

Cole v. ArvinMeritor, Inc.,
549 F.3d 1064 (6th Cir. 2008) 7, 12, 19, 20

Cole v. ArvinMeritor, Inc.,
516 F.Supp.2d 850 (E.D. Mich. 2005) 20

Dewhurst v. Century Aluminum Co.,
649 F.3d 287 (4th Cir. 2011) 18

Gable v. Sweetheart Cup Co., Inc.,
35 F.3d 851 (4th Cir. 1994) 16

Golden v. Kelsey-Hayes Co.,
73 F.3d 648 (6th Cir. 1996), *cert. denied* 519 U.S.
807 (1996) 11, 12, 19

Golden v. Kelsey-Hayes Co.,
954 F.Supp. 1173 (E.D. Mich. 1997) 7, 20

Golden v. Kelsey-Hayes Co.,
845 F.Supp. 410 (E.D. Mich. 1994), *aff'd.* 73 F.3d 648 (6th Cir. 1996), *cert. denied* 519 U.S. 807 (1996) 7

Grain Millers v. International Multifoods Corp.,
116 F.3d 976 (2d Cir. 1997) 15

Helwig v. Kelsey Hayes, Co.,
93 F.3d 243 (6th Cir. 1996) 15

Keffer v. H.K. Porter Co.,
872 F.2d 60 (4th Cir. 1989) 18

Machinists v. Masonite Corp.,
122 F.3d 228 (5th Cir. 1997) 15, 16

Maurer v. Joy Technologies, Inc.,
212 F.3d 907 (6th Cir. 2000) 7, 11, 12, 14, 22

McCoy v. Meridian Automotive Systems, Inc.,
390 F.3d 417 (6th Cir. 2004) 7, 12

Menasha Corp. v. Moore,
133 S. Ct. 1643 (2013) 15

Moore v. Menasha Corp.,
690 F.3d 444 (6th Cir. 2012) 14, 20

Moore v. Menasha Corp.,
724 F.Supp.2d 795 (W.D. Mich. 2010) 20

Newell Window Furnishings, Inc. v. Bender,
133 S. Ct. 436 (2012) 14, 15

Noe v. PolyOne Corp.,
520 F.3d 548 (6th Cir. 2008) 7, 9, 10, 12, 13

Policy v. Powell Pressed Steel Co.,
770 F.2d 609 (6th Cir. 1985), *cert. denied*, 475
U.S. 1017 (1986) 7, 15

Reese v. CNH America, LLC,
574 F.3d 315 (6th Cir. 2009) 10, 12, 16

Rose v. Volvo Const. Equip. N.A., Inc.,
331 Fed.Appx. 388 (6th Cir. 2009), *cert. denied*,
130 S. Ct. 1731 (2010) 15

Rossetto v. Pabst Brewing Company,
217 F.3d 539 (7th Cir. 2000) 14, 17

Senior v. NSTAR Electric and Gas Corp.,
449 F.3d 206 (1st Cir. 2006) 15

Smith v. ABS Industries, Inc.,
890 F.2d 841 (6th Cir. 1989) 7

Tackett v. M&G Polymers,
733 F.3d 589 (6th Cir. 2013) 13

UAW v. BVR Liquidating, Inc.,
190 F.3d 768 (6th Cir. 1999), *cert. denied* 529
U.S. 1067 (2000) 15, 16

UAW v. Cadillac Malleable Iron Co., Inc.,
728 F.2d 807 (6th Cir. 1984) 8, 9, 10, 12

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873 F.Supp. 57 (N.D. Ohio 1994), later decision,
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U.S. App. LEXIS 2118 (6th Cir. 1997) 8, 9

UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) 15, 16, 17

UAW v. Yard-Man,
716 F.2d 1476 (6th Cir. 1983) ..... *passim*

In re Unisys Corp. Retiree Medical Ben. ERISA Litigation,
58 F.3d 896 (3d Cir. 1995) 16

United Steelworkers of Am v. Connors Steel Co.,
855 F.2d 1499 18

Weimer v. Kurz-Kasch, Inc.,
773 F.2d 669 (6th Cir. 1985) 7

Winnett v. Caterpillar, Inc.,
553 F.3d 1000 (6th Cir. 2009) 17

Yolton v. El Paso Tennessee Pipeline Co.,
435 F.3d 571 (6th Cir. 2006) ..... *passim*

RULES

Sup. Ct. R. 10 ..... 1, 2, 23

OTHER AUTHORITIES

E. Gressman, *et al. Supreme Court Practice* (9th ed. 2007) § 5.12(c)(3) 2

INTRODUCTION AND SUMMARY OF ARGUMENT

Petitioner M&G seeks certiorari to resolve a fact-based trial decision in a case where the employer's effective elimination of health benefits for hundreds of retirees and their dependents was determined following a bench-trial to violate the collective bargaining agreements (CBAs) which governed. Resp. App. 1.[1] Plaintiffs prevailed following the six-day bench trial, where they proved the retiree health benefits are vested for life. Defendants appealed a judgment and permanent injunction ordering M&G to provide the retiree benefits to Class Members. Pet. App. 25.[2] The Sixth Circuit affirmed the trial decision. Pet. App. 23.

Now, M&G in effect fabricates a circuit split to convince this Court to intervene in this quotidian matter of contract enforcement. M&G's argument failed to convince the trial court. M&G's argument failed to convince the appellate court. M&G is a party to contracts that obligate M&G to provide lifetime benefits to retirees and their eligible dependents. This is ordinary contract enforcement, and while M&G veils its request as resolution of a circuit split, what M&G actually seeks is release from a contract. This case presents no "erroneous factual findings or . . . misapplication of a properly stated rule of law," and thus is not worthy of review according to Sup. Ct. R. 10.

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[1] "Resp. App." refers to the appendix to the brief in opposition in No. 13-1010.

[2] "Pet. App." refers to the appendix to the petition for certiorari in No. 13-1010.

Here, even if M&G were able to identify any "erroneous factual findings" or "misapplication" of any "rule of law"—which M&G does not and cannot do—any such "errors" and "misapplications" are fact-specific, solely of consequence to the parties' unique dispute, and "outside the mainstream of the court's functions." See E. Gressman, *et al. Supreme Court Practice* (9th ed. 2007) § 5.12(c)(3) at 351.

At trial, two M&G witnesses provided "dubious testimony" that "wholly lacked veracity" in an attempt to persuade the court. Resp. App. 32-34, 40. The District Court determined that no side letters capping M&G's liability applied and that benefits were vested for life, a finding that stands as an issue of fact, reviewable only for clear error. See *AT&T Mobility LLC v. Concepcion,* 131 S. Ct. 1740, 1752 (2011). The District Court did not err in its determination in this matter, nor did the Sixth Circuit in affirming that holding. In sum, there is no inconsistency between the Sixth Circuit decision and standing precedent, nor anything in the Sixth Circuit's application of traditional contract interpretation rules that warrants this Court's review of this garden-variety, fact-specific, contract dispute.

M&G's petition for certiorari should be denied. This case presents no important or recurring issues of federal law and is not worthy of review under Sup. Ct. R. 10. This is a fact-specific dispute, resolved at trial and affirmed on appeal, and the decisions of the trial court and the Sixth Circuit should remain.

COUNTERSTATEMENT OF THE CASE

M&G purchased a polyester resin facility in Point Pleasant, West Virginia in 2000. Pet. App. 34. Workers at Point Pleasant have historically been represented by Local 644, now part of the USW. *Id.*, 32-34. At the heart of this case are collectively bargained promises of retirement healthcare that M&G asserted it had the right to unilaterally limit, with cost-sharing assigned to Retirees. Following trial, the Court found the healthcare benefits had vested for life and were not subject to cost-sharing. Resp. App. 32-42.

Benefits vested according to the terms of a contractually bargained Pension & Insurance (P&I) Agreement. The 1991 P&I booklet that controlled benefits in Point Pleasant had clear vesting language for retiree health benefits. In 1994, the P&I booklet adopted in Point Pleasant contained new vesting language regarding retiree health benefits, which promised a "full company contribution" for healthcare to persons receiving a monthly pension. Resp. App. 4. The 1997 and 2000 P&I Agreements contained identical vesting language. Resp. App. 4.

Several years later, in 2005, M&G and the USW reached an agreement that established caps on M&G's contribution toward the costs of **future** retirees' healthcare premiums. Resp. App. 36-38. The benefits for retirees who retired after August 9, 2005 are no longer at issue. In 2007, M&G began to implement caps on retiree benefits for **all** hourly retirees, shifting substantial monthly costs for healthcare to Class Members. Resp. App. 12-14. M&G terminated healthcare coverage for those Class Members unable to

pay the substantial added costs; other retirees dropped coverage due to the substantial costs.

District Court Decisions At Issue.

A. The Liability Decision.

Following a six-day bench trial, the District Court determined the retiree health benefits to be lifetime, vested benefits, without retiree contribution. Resp. App. 26-33. The Court found the contractual "linking of eligibility for healthcare benefits to pension benefits indicates the parties' intent that healthcare benefits vested upon retirement." *Id.* at 30-31.

The District Court next analyzed the evidence presented by each witness, *determined their credibility* (Resp. App. 11-25), and concluded that prior to 2005, cap letters limiting M&G's liability for healthcare **never** formed a part of the M&G — USW contracts:

> On one side, **Defendants have presented largely dubious testimony** . . . . On the other side, **Plaintiffs have presented notably more compelling evidence** that Defendants have engaged in after-the-fact company scrambling to find a way to impose unilaterally application of cap letters as a cost-savings measure that defies the agreements the caps puncture.
>
> **[T]he intent and effect of the applicable operative documents governing Subclasses One through Four present a lifetime benefits scheme for qualifying retirees and beneficiaries without the cost-sharing Defendants wrongly imposed.**

Id. at 32-33 (emphasis added).

The District Court rejected key M&G testimony as "simply not credible" *Id.* at 38-39. In contrast, the Court found credible the testimony of Plaintiffs' key witnesses. Resp. App. 39. Importantly, the Court's final conclusion rejected M&G's position, and found:

> **Plaintiffs have presented ample evidence involving M&G's counsel, actuaries, and human resources personnel that no one thought that there was a cost-sharing plan in place for Apple Grove retirees for years until it became advantageous to the company . . . . Those who testified supporting cap letter applicability wholly lacked veracity.**

Id. at 40 (emphasis added).

B. The Injunction Decision.

Following the trial determination, the District Court granted a permanent injunction, restoring the Class Members to their respective Plans, and requiring a cessation of contributions. Pet. App. 25. The injunction decision incorporated the liability decision, and emphasized key factual findings, including credibility determinations.

ARGUMENT

I. M&G's Arguments For Certiorari Lack Merit.

M&G attempts to obscure the clear factual record in this matter under the guise of a non-existent circuit conflict. This is an ordinary matter of contract enforcement.

A. The Sixth Circuit Does Not Apply Presumptions In LMRA/ERISA Retirement Healthcare Cases.

M&G's argument rests on the premise that the Sixth Circuit is unable to distinguish between an "inference" and a "presumption." M&G suggests that the multiple Sixth Circuit panels making this distinction—applying an inference when factually warranted and *never* applying a presumption—are not to be taken at their word.

1. An Inference And A Presumption Are Not Equivalent.

To foster its false premise, M&G repeatedly confuses the existence of a presumption with that of an inference, and apparently believes that repetition of the word "presumption" in its petition somehow will change the Sixth Circuit standard. M&G asserts that plaintiffs "who would lose in most jurisdictions can prevail if they are fortuitous enough to have at least one retiree member of their putative class living in Michigan, Ohio, or Kentucky." Petition at 7. This is hyperbole, and it ignores the Sixth Circuit cases holding that specific contractual terms demonstrate the

parties' intent to vest retiree healthcare.[3] It also

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[3] Many cases listed decided by the Sixth Circuit find vested benefits based on specific CBA terms. See, *e.g.*, (1) *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 262 (6th Cir. 2012), *cert. denied* 133 S.Ct. 436 (2012) (the CBAs "specifically stated that '[t]he Company agree[d] to pay the cost of such insurance for the retiree and his dependents'"); (2) *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, 1070 (6th Cir. 2008) (healthcare at the "time of retirement...shall be continued thereafter"); (3) *McCoy v. Meridian Automotive Systems, Inc.*, 390 F.3d 417, 419 (6th Cir. 2004) ("coverages an employee has...at the time of retirement...shall be continued thereafter"); (4) *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 912 (6th Cir. 2000) ("For pensioners and spouses under age 65, the retiree Group Insurance Program...will remain in effect"); (5) *Golden v. Kelsey-Hayes Co.*, 845 F.Supp. 410 (E.D. Mich. 1994), *aff'd.* 73 F.3d 648 (6th Cir. 1996), *cert. denied* 519 U.S. 807 (1996), and 954 F.Supp. 1173, 1178 (E.D. Mich. 1997) (the company "shall contribute the full premium" for the "health care coverages" an employee has "at the time of retirement" and those coverages "shall be continued thereafter"); (6) *Smith v. ABS Industries, Inc.*, 890 F.2d 841, 843 (6th Cir. 1989), *reh. denied* (6th Cir. 1990) (healthcare "[b]enefits will continue for retirees"); (7) *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609, 611, 615 (6th Cir. 1985), *cert denied* 475 U.S. 1017 (1986)("hospitalization and surgical benefits for the pensioner and his spouse...during the life of the pensioner at no cost to the pensioner"); (8) *Weimer v. Kurz-Kasch, Inc.*, 773 F.2d 669, 674-675(6th Cir. 1985)("the four corners of the" CBA provide that retiree benefits "shall continue" "so long as such Employees are, in fact, retired and remain unemployed").

Other cases find vesting promises in contractual context. See, *e.g.*, (1) *Noe v. PolyOne Corp.*, 520 F.3d 548, 558-560 (6th Cir. 2008)(benefits from age 65 "until the individual's death," lifetime "special" Medicare payments, and CBA terms which "tie eligibility for retiree health benefits directly to eligibility for pension benefits"); (2) *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571, 584-585 (6th Cir. 2006), *cert. denied* 549 U.S. 1019 (2006)("the district court correctly interpreted the plain language of the CBAs

ignores the reality that *in this case*, following a six-day trial, the fact-finder (1) found that M&G's witnesses lacked any credibility and (2) concluded that Plaintiffs had proven that lifetime, vested benefits were promised. Resp. App. 32-34, 40.

2. The Vesting Language Present Here Has Long Been Acknowledged To Solidify Lifetime, Vested Healthcare Benefits.

Additionally, in the face of strikingly similar language to that seen here and in contracts throughout the rubber industry, the Sixth Circuit long ago affirmed that such language created vested, lifetime benefits. In *UAW v. Loral*, nearly identical language was examined by the Sixth Circuit and found to provide lifetime, vested benefits. The *Loral* language stated that "Employees who retire . . . eligible . . . for a pension . . . shall receive the . . . benefits described in this Section B . . . ." *UAW v. Loral*, 873 F.Supp. 57, 63-64 (N.D. Ohio 1994), later decision, 873 F.Supp. 66 (N.D. Ohio 1995), aff'd, 1997 U.S. App. LEXIS 2118 (6th Cir. 1997). This language is nearly identical to the vesting language of the P&I Agreements, was found to create

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and Group Insurance Plans as well as the agreement as a whole. The language tying health care benefits to pension benefits and the context of the bargaining demonstrate an intent to provide lifetime benefits"); (3) *UAW v. Cadillac Malleable Iron Co., Inc.*, 728 F.2d 807, 809 (6th Cir. 1984) ("On the basis of the entire record the district court concluded that the plaintiffs had established that it was the intent of the parties that these rights not be affected by the expiration of the collective bargaining agreements which created them, confirmed them and often improved the benefits of already retired employees.").

vested benefits, and supports the conclusion of the District Court in this action. See *Id.*, see also *Noe v. PolyOne Corp.*, 520 F.3d 548, 562 (6th Cir. 2008). Indeed, *Loral* was decided at summary judgment, and had strikingly similar vesting language. Even had a trial on the merits not been conducted in this matter, the contract language supports a finding in favor of retirees.

3. The Enforcement Of Contractual Promises Results In No Detriment.

M&G argues that there is a "presumption" creating a "tilted" playing field in the Sixth Circuit, to "the detriment of workers and the economy, too." Petition at 12, 25. In fact, the Sixth Circuit decisions demonstrate that retiree successes are not guaranteed, and no presumption plays a role in their outcome. Nowhere, in the Sixth Circuit or elsewhere, does a LMRA Section 301 case alter traditional evidentiary standards or otherwise shift the burden to a defendant. M&G does not identify a single case in which a court imposed any such requirement. LMRA/ERISA cases are hard-fought, vigorously defended, and decided on the evidence; typically in detailed, reasoned, well-documented, fact-specific, presumption-free decisions, informed by traditional contract-interpretation rules, refined by 30-plus years of nuanced, Sixth Circuit jurisprudence, and *proof*. Here, the proof was presented during a lengthy trial in which the fact-finder was convinced that benefits were vested for life—no presumption was applied to reach that result.

4. The Sixth Circuit Has Repeatedly Rejected A Presumption In Favor Of Vesting.

M&G cites to Judge Sutton, dissenting in *Noe v. Polyone Corp.*, 520 F.3d 548, 568, for the premise that a presumption in favor of vesting exists. Petition at 10-11. But even Judge Sutton, in an opinion that followed *Noe*, wrote for a majority that LMRA/ERISA retiree healthcare cases are decided on "ordinary principles of contract interpretation." He explained: "to the extent we put a thumb on the scale in this setting it favors vesting," but this "nudge" comes *only* in "close cases" *and only* if "we can find either explicit contractual language or extrinsic evidence indicating an intent to vest benefits." *Reese v. CNH America, LLC*, 574 F.3d 315, 321 (6th Cir. 2009)(citations and internal quotations omitted). He wrote that the "precise weight" of the *Yard-Man* inference is "elusive," but it is not alone sufficient to find "an intent to create interminable benefits" and it is *not* a "legal presumption that benefits vest."

The Sixth Circuit has regularly refuted the "presumption" arguments now repeated by M&G. See *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571, 579 (6th Cir. 2006):

> Shortly after [*UAW v.*]*Yard-Man*, [*Inc.*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied* 465 U.S. 1007 (1984)], this Court stated that "there is no legal presumption based on the status of retired employees." *Int'l Union, United Auto. Workers v. Cadillac Malleable Iron Co.*, 728 F.2d 807, 808 (6th Cir. 1984). Moreover, "*Yard-Man* does not shift the burden of proof to the employer, nor

> does it require specific anti-vesting language before a court can find that the parties did not intend benefits to vest. Rather, the *Yard-Man* inference, and the other teachings of the opinion regarding contract interpretation and the consideration of extrinsic evidence, simply guide courts faced with the task of discerning the intent of the parties from vague or ambiguous CBAs." *Golden* [*v. Kelsey-Hayes Co.*], 73 F.3d [648,] at 656 [(6th Cir. 1996), *cert. denied* 519 U.S. 807 (1996)].

Yolton observed that the employers "misinterpret the term 'inference' and confuse it with a legal presumption" and explained: "Under *Yard-Man* we may *infer* an intent to vest from the context and already sufficient evidence of such intent. Absent such other evidence, we do not start our analysis presuming anything." *Yolton,* 435 F.3d at 579 (emphasis in original). *Yolton* also quoted *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 917 (6th Cir. 2000): "under *Yard-Man*, '[t]here is no legal presumption that benefits vest and that the burden of proof rests on plaintiffs.'" *Yolton,* 435 F.3d at 580. *Yolton* explains that the inference merely provides "a contextual understanding about the nature of labor-management negotiations over retirement benefits" and states that "[t]his Court has never inferred an intent to vest benefits in the absence of either explicit contractual language or extrinsic evidence indicating such an intent. *Yolton,* 435 F.3d at 580.[4]

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[4] See also: (1) *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 261 (6th Cir. 2012), *cert. denied* 133 S.Ct. 436 (2012) ("With regard to the '*Yard-Man* inference,' later decisions of this

In sum, the Sixth Circuit has debunked the "presumption" arguments—now repeated by M&G—in *Cadillac Malleable* in 1984, in *Golden* in 1996, in *Maurer* in 2000, in *McCoy* in 2004, in *Yolton* in 2006, in *Noe* and *Cole* in 2008, in *Reese* in 2009, in *Bender* in 2012, and this Court denied *cert* in *Yard-Man*, *Golden*, *Yolton*, and *Bender*. And again, the decision below similarly debunks the "presumption" arguments by applying traditional presumption-free contract interpretation rules. The Sixth Circuit's record of "never" applying presumptions in LMRA/ERISA retirement healthcare cases is unmarred.

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court have clarified that *Yard-Man* does not create a legal presumption that retiree benefits are interminable"); **(2)** *Reese v. CNH America LLC*, 574 F.3d 315, 321 (6th Cir. 2009)("we do not apply a 'legal presumption that benefits vest'"); **(3)** *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, 1069 (6th Cir. 2008)("*Yard-Man* does not create a legal presumption that retiree benefits are vested for life"); **(4)** *Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008) ("*Yard-Man* does not create a legal presumption that retiree benefits are interminable"); **(5)** *McCoy v. Meridian Automotive Systems, Inc.*, 390 F.3d 417, 422 (6th Cir. 2004)("While *Yard-Man* recognized an inference that 'status' benefits, including retiree benefits, continue as long as the status is maintained, it also noted that such benefits are not necessarily interminable and no federal labor policy establishes a presumption of vesting."); **(6)** *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 917 (6th Cir. 2000)("there is no legal presumption that benefits vest"; the "burden of proof rests on plaintiffs"); **(7)** *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 656 (6th Cir. 1996), *cert. denied* 519 U.S. 807 (1996)("shortly after *Yard-Man* this Court stated: 'there is no legal presumption based on the status of retired employees,'" quoting *Cadillac Malleable*, 728 F.2d at 808); and **(8)** *Yard-Man*, 716 F.2d at 1482.

B. The Case Is Determined By "Traditional Rules Of Contract Interpretation" And The "Overwhelming" Evidence.

The Sixth Circuit below applied the traditional rules of contract interpretation. The Sixth Circuit noted that welfare benefit plans do "not vest automatically, but only 'if the parties so intended when they executed the applicable labor agreements.'" *Tackett v. M&G Polymers*, 733 F.3d 589 (6th Cir. 2013), quoting *Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008). Pet. App. 10. The Court noted that it applied "general principles of contract interpretation." Pet. App. 12.

Any "nudge" that might have been provided by the *Yard-Man* inference is superfluous here. This is not a "close case." The Sixth Circuit decision is overwhelmingly justified by the evidence presented at trial. Of particular import were the credibility determinations. M&G's witnesses presented testimony found by the trial court to be "self-serving" and "dubious," and which "wholly lacked veracity." Resp. App. 39, 32, 40. In contrast, the evidence presented by Plaintiffs that the parties had intended the healthcare benefits to vest for life was "compelling." Resp. App. 32.

C. There Is No "Irreconcilable" Conflict Or Legal Inconsistency Between The Sixth Circuit And Other Circuits, All Of Which Apply Traditional Contract Interpretation Rules To Fact-Specific Circumstances To Resolve Retirement Healthcare Disputes.

M&G posits a supposed "irreconcilable" conflict between the Sixth and other circuits in LMRA/ERISA retirement healthcare cases. No such conflict exists. Defendants repeatedly cite to Judge Posner's *Rossetto* statement that the circuits are "all over the lot." See *Rossetto v. Pabst Brewing Company*, 217 F.3d 539, 543 (7th Cir. 2000). But Judge Posner got it wrong. *Id.* *Rossetto* cites to *Maurer,* 212 F.3d 907 (6th Cir. 2000), suggesting that the Sixth Circuit applied a presumption of vesting, but *Maurer* states the opposite. In *Maurer*, the employer argued that there was a presumption against vesting. The court plainly stated that while "ERISA does not require vesting of such benefits parties may agree to create and vest them." *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 917 (6th Cir. 2000). *Maurer* did not apply any presumption in favor of vesting, and so Judge Posner missed the mark.

1. This Court Has Repeatedly Rejected Certiorari In These Garden-Variety Contract Interpretation Cases.

This same "conflict" argument was made in the recent *certiorari* petitions in *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253 (6th Cir. 2012) and *Moore v. Menasha Corp.*, 690 F.3d 444 (6th Cir. 2012). This Court denied the petitions *sub nom Newell*

Window Furnishings, Inc. v. Bender, 133 S. Ct. 436 (2012) and *Menasha Corp. v. Moore*, 133 S. Ct. 1643 (2013). The "conflict" argument was made in numerous earlier *certiorari* petitions and also rejected.[5]

2. All Circuits Employ Similar Methods When Determining LMRA/ERISA Matters.

Analytical approaches among the circuits vary, but every circuit resolves LMRA/ERISA retirement healthcare cases by applying traditional contract interpretation rules. The circuits all hold that retirement healthcare promises are enforceable under the LMRA, or ERISA, or both. All apply the same core rules: **(1)** healthcare benefits do not automatically vest[6]; **(2)** parties to CBAs may nevertheless agree to

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[5] See, *e.g.*, *Rose v. Volvo Const. Equip. N.A., Inc.*, 331 Fed.Appx. 388 (6th Cir. 2009), *cert. denied* 130 S.Ct. 1731 (2010); *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006), *cert. denied* 549 U.S. 1019 (2006); *UAW v. BVR Liquidating, Inc.*, 190 F.3d 768 (6th Cir. 1999), *cert. denied* 529 U.S. 1067 (2000); and *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609 (6th Cir.1985), *cert. denied* 475 U.S. 1017 (1986).

[6] See *Helwig v. Kelsey Hayes, Co.*, 93 F.3d 243, 248 (6th Cir. 1996); *Grain Millers v. International Multifoods Corp.*, 116 F.3d 976, 980 (2d Cir. 1997); *Senior v. NSTAR Electric and Gas Corp.*, 449 F.3d 206, 207 (1st Cir. 2006); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 137-138 (3d Cir. 1999); *Machinists v. Masonite Corp.*, 122 F.3d 228, 231 (5th Cir. 1997); *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 604-605 (7th Cir. 1993), *cert. denied* 510 U.S. 909 (1993); *Cherry v. Auburn Gear, Inc.*, 441 F.3d 476, 481 (7th Cir. 2006); *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988), *cert. denied* 489 U.S. 1051 (8th Cir. 1989).

vest retirement healthcare[7]; **(3)** basic rules of contractual interpretation apply; **(4)** extrinsic evidence may be used to interpret ambiguous CBAs[8]; **(5)** and plaintiffs have the burden of proof.[9]

The outcomes of these cases invariably depend on the CBA language and, as necessary to resolve contractual ambiguity, on the case-specific extrinsic evidence and admissions showing the intent of the contracting parties. Each circuit applies the traditional interpretation rules to the particular CBA terms and the parties' particular circumstances; no circuit applies

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[7] See *Yard-Man*, 716 F.2d at 1479; *UAW v. Skinner Engine Co.*, 188 F.3d 130, 138 (3d Cir. 1999); *Machinists v. Masonite Corp.*, 122 F.3d 228, 231 (5th Cir. 1997); *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 607 (7th Cir. 1993), *cert. denied* 510 U.S. 909 (1993); *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1516 (8th Cir. 1988), *cert. denied* 489 U.S. 1051 (8th Cir. 1989).

[8] See *UAW v. BVR Liquidating, Inc.*, 190 F.3d 768, 772 (6th Cir. 1999), *cert. denied* 529 U.S. 1067 (2000); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 138, 142 (3d Cir. 1999); *Machinists v. Masonite Corp.*, 122 F.3d 228, 233 (5th Cir. 1997); *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 608-609 (7th Cir. 1993), *cert. denied* 510 U.S. 909 (1993); *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988), *cert. denied* 489 U.S. 1051 (8th Cir. 1989).

[9] See *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988), *cert. denied* 489 U.S. 1051 (8th Cir. 1989); *Machinists v. Masonite Corp.*, 122 F.3d 228, 231 (5th Cir. 1997); *Reese v. CNH America, LLC*, 574 F.3d 315, 321 (6th Cir. 2009), *reh'g denied* 583 F.3d 955 (6th Cir. 2009); *In re Unisys Corp. Retiree Medical Ben. ERISA Litigation*, 58 F.3d 896, 902 (3d Cir. 1995); *Gable v. Sweetheart Cup Co., Inc.*, 35 F.3d 851, 855 (4th Cir. 1994).

an overarching legal rule to resolve fact-specific cases such as this one.

3. Decisions Cited By M&G Point Out That Traditional Rules Of Contract Interpretation Apply.

Indeed, M&G's account of other circuits' decisions reveals that all circuits, like the Sixth, recognize the core task as applying traditional interpretation rules to disputed CBA terms. While some circuits use, and some decline to use, "inferences" and similar analytical devices to interpret CBAs, all require plaintiffs to present CBA terms and, as necessary to resolve ambiguity, extrinsic evidence, to *prove* the contractual intent to vest retiree healthcare. For example, the Seventh Circuit may apply a "presumption against vesting" but "only if all the court has to go on is silence." *Rossetto v. Pabst Brewing Co., Inc.*, 217 F.3d 539, 544 (7th Cir. 2000). This does not materially differ from the Sixth Circuit approach. The Sixth Circuit declines to infer lifetime retirement healthcare where there is CBA silence—*i.e.*, where no "reasonably interpreted" CBA language may promise vesting—and the Sixth Circuit declines to consider extrinsic evidence absent CBA ambiguity. See *Winnett v. Caterpillar, Inc.*, 553 F.3d 1000, 1008-1110 (6th Cir. 2009).

Fourteen years ago, the Third Circuit in *UAW v. Skinner Engine Co.*, 188 F.3d 130, 139-141 (3d Cir. 1999) disagreed with *Yard-Man* in dicta, but there is no substantive conflict between *Skinner* and any Sixth Circuit case. The disagreement is based on the Third Circuit's *mistaken* belief that *Yard-Man* applies a presumption in favor of vesting. 188 F.3d at 140. As noted, before and since *Skinner,* the Sixth Circuit has

made clear that no presumption applies. See *Yolton*, 435 F.3d at 579-580, and the cases cited in Argument Section A.

M&G asserts that the "Eleventh Circuit has also cited *Yard-Man* with approval and expressly adopted its presumption." Petition at 14 (citing *United Steelworkers of Am v. Connors Steel Co.*, 855 F.2d 1499, 1505). On the contrary, the Eleventh Circuit neither mentioned a presumption, which is non-existent in *Yard-Man*, nor adopted one. And, as with cases from the Sixth Circuit, we search in vain for any evidence that the Eleventh Circuit has altered traditional burdens or applied a legal presumption in retiree healthcare cases. The Eleventh Circuit applied standard rules of interpretation to conclude that a "general termination clause does not support a finding that retiree benefits ended when the agreements expired." *Connors Steel Co.*, 855 F.2d at 1505.

Dewhurst v. Century Aluminum Co., 649 F.3d 287, 291-292 (4th Cir. 2011), illustrates that the *Yard-Man* inference commonly has no practical impact. *Dewhurst* points out that *Keffer v. H.K. Porter Co.*, 872 F.2d 60 (4th Cir. 1989) was decided on the "specific [CBA] language" and on the "alternative finding that extrinsic evidence supported our conclusion," making *Keffer*'s favorable reference to *Yard-Man* superfluous, *i.e.*, "not necessary to our holding," finding vested retirement healthcare. Every case turns on CBA terms, and as necessary to resolve ambiguity, situation-specific extrinsic evidence. Contrary to what M&G suggests, these cases are garden-variety contract cases, not worthy of certiorari.

4. Minor Differences In Approach Between Circuits Are Not Conflicts.

The Sixth and other circuits may display minor differences in approach to the traditional contract interpretation rules. Minor differences, however, are also reflected within circuits from one three-judge panel to another, and even among panel members reaching consensus on results. Various judges use various approaches, but the facts resolve these cases. And all the circuits, and panels and judges in all circuits, apply in substance the rules set out in *Yard-Man* in 1983, repeated in substance in the decision below and in most if not every LMRA/ERISA decision in every circuit. Again, the "court should first look to the explicit language of the collective bargaining agreement for clear manifestations of intent" and "may look to other words and phrases in the collective bargaining agreement for guidance," consider the contractual "context," "interpret each provision in question as part of the integrated whole" and construe the terms "so as to render none nugatory and avoid illusory promises." See *Yard-Man*, 716 F.2d at 1479-1480; *Cole*, 549 F.3d at 1069-1070; *Yolton*, 435 F.3d at 579; *Golden*, 73 F.3d at 654-655.

Where CBA terms are ambiguous, the courts ascertain intent from "extrinsic" evidence, like bargaining history, "course of conduct," and statements, *i.e.*, the parties' "words and deeds." Courts

also use "extrinsic" evidence to confirm unambiguous intent.[10]

Indeed, M&G's assertion that the overwhelming evidence in this case would have resulted in a different outcome in another circuit is purely conclusory. No basis exists to conclude the trial court could have reached differing conclusions — the facts compelled the decision. We search in vain for a case, from any circuit, which contains anything near the wealth of evidence supporting the court's conclusion in this matter and yet reaches a different result. In the end, retirees must prove their cases. Retirees cannot prevail in the Sixth Circuit or anywhere else absent "explicit contractual language or extrinsic evidence" *proving* "an intent to vest." *Moore v. Menasha Corp.*, 690 F.3d 444, 450 (6th Cir. 2012) (citations and internal quotations omitted). The language in the contracts at issue in this matter demonstrates an intent to vest. If any question of that intent existed, it was resolved at trial where the Plaintiffs presented "compelling" evidence of the intent to vest lifetime healthcare benefits.

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[10] See *Cole v. ArvinMeritor, Inc.*, 516 F.Supp.2d 850, 861-864, 871-876 (E.D. Mich. 2005), and 515 F.Supp.2d at 805, *aff'd* 549 F.3d at 1070, 1074-1075 (6th Cir. 2008) (the "shall be continued thereafter" language "creates an unambiguous promise for lifetime healthcare benefits" and alone warrants judgment for the retirees, but also noting that the "extrinsic" evidence "weighs heavily" to confirm that promise); *Golden v. Kelsey-Hayes Co.*, 954 F.Supp. 1173, 1188 (E.D. Mich. 1997) (judgment for retirees based on "express contract language," confirmed by "extrinsic" evidence); *Moore v. Menasha*, 724 F.Supp.2d 795, 807 (W.D. Mich. 2010) (on "its face" the 1997 CBA "clearly obligates" Menasha to "provide lifetime health insurance benefits to employees who retire" and "the *Yard-Man* inference and extrinsic evidence only strengthen this conclusion").

In sum, there is no "irreconcilable conflict" among the circuits. Indeed, the outcome in this case would have been the same in any circuit based on the undisputed and overwhelming evidence *proving* that M&G's predecessors *promised* lifetime company-paid retirement healthcare for their retirees. There is no legal inconsistency among the circuits that merits this Court's review.

II. Both Contractually Bargained Benefits And Standard ERISA Plans Are Determined According To Standard Rules Of Contractual Interpretation, But The Context For Interpretation Is Markedly Different.

Both standard ERISA plans and contractually bargained plans are interpreted in accordance with traditional rules of contract interpretation. But with standard ERISA plans, a plan is created according to a company's wishes, and is subject to unilateral changes by that company. In that setting, logic demands that a plan would favor a company rather than plan participants in regard to vesting, for the employees and plan participants had no input in the creation of the benefit plan: the employer had all the control.

The same is not true in the context of collectively bargained benefits. M&G suggests that collective bargaining and the provision of benefits in accordance with CBAs is "simple," when it is anything but. When benefits have been collectively bargained, parties bargain for benefits that will be fixed, rather than malleable. See *Int'l Union v. Yard-Man*, 716 F.2d 1476, 1482 (6th Cir. 1983). Union negotiators, knowing they themselves would become retirees, would not be willing

to allow their benefits, as included in a CBA, to be subject to the contingencies of future negotiations. *Id.*

In contrast, non-unionized, employees-at-will are subject to an even more unpredictable reality: the contingencies of employers' generosity. At-will employees are without the same ability to bargain their own retiree health benefit package. M&G's argument in this context does not outline a conflict in vesting interpretation. Because a package of ERISA benefits that was not collectively bargained is declared according to the wishes of the employer and that employer alone, the task of interpretation is simple in comparison to interpretation of vesting clauses within CBAs. In neither case does the Sixth Circuit apply a presumption. See *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 917 (6th Cir. 2000)("ERISA does not require vesting of such benefits, parties may agree to create and vest them.").

III. Regardless Of The Legal Standards Applied, M&G Cannot Overcome The Substantial Findings Of Fact Which Undermine Its Case, And Therefore M&G's Petition For Certiorari Is Futile.

The trial court decided this case based on facts and evidence, and the Sixth Circuit affirmed. No presumptions of law formed any basis for the decisions, nor does this case present a circuit split or an important matter of federal law. The trial court in this matter assessed all evidence, and applying no presumptions, found that Plaintiffs presented "compelling evidence that Defendants have engaged in after-the-fact company scrambling to find a way to

impose unilaterally application of cap letters as a cost-savings measure that defies the agreements." Resp. App. 32-33. The intent of the parties established that there was "a lifetime benefits scheme for qualifying retirees and beneficiaries." *Id.*

While the courts below applied no presumption in this case, M&G's focus on non-existent circuit splits in their petition is to the exclusion of facts which favor the Plaintiffs. Regardless of the manner in which the contracts at issue were to be interpreted, Plaintiffs have proven their case. The case presented at trial by M&G was "dubious," "self-serving," and "wholly lacked veracity." Resp. App. 32, 39, 40. In these circumstances, M&G is left without recourse or remedy. A return to the trial court in this matter would render no different result than that which has already been reached. No error has occurred in this matter, no actual issue worthy of review by this Court has been raised, and M&G's petition for certiorari should be denied.

CONCLUSION

For the reasons summarized above, M&G's petition for writ of certiorari should be denied. This case presents no "erroneous factual findings or . . . application of a properly stated rule of law," and thus is not worthy of review pursuant to Sup. Ct. R. 10.

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APPENDIX

APPENDIX

TABLE OF CONTENTS

Appendix 1 Opinion and Order in the United States District Court Southern District of Ohio Eastern Division (August 5, 2011) . . . . . App. 1

APPENDIX 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

Case No. 2:07-cv-126
JUDGE GREGORY L. FROST
Magistrate Judge Norah McCann King

[Filed August 5, 2011]

HOBERT FREEL TACKETT, et al.,)
Plaintiffs,)
)
v.)
)
M&G POLYMERS USA, LLC, et al.,)
Defendants.)

OPINION AND ORDER

This is a class action case in which Plaintiffs assert that Defendants have violated their right to lifetime contribution-free health care benefits. The matter came on for a bench trial in May 2011 on the issue of liability. For the reasons that follow, the Court finds in favor of those plaintiffs in Subclasses One through Four and against Defendants, but in favor of Defendants and against those plaintiffs in Subclass Five.

I.

A. Background

The class (retirees, their spouses, and surviving spouses or other dependents of individuals who worked for the named defendant company) assert that although they have a right to lifetime retiree health care benefits, the company is requiring them to pay for those benefits in violation of various collective bargaining agreement ("CBA") provisions.[1] Plaintiffs

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[1] The parties have agreed on the class and subclasses involved, which are as follows:

Class:

All retired employees of M&G PolymersUSA, LLC ("M&G") and/or its predecessor company, the Shell Chemical Company ("Shell"), who worked at the Point Pleasant Polyester Plant ("Plant") in Apple Grove, West Virginia and were represented by the USW or its predecessor unions ("Union") in collective bargaining, and who retired or left service from the Plant having met the eligibility requirements for retiree health care benefits specified in the applicable collective bargaining agreements ("CBAs") and P&I Agreements, as well as the spouses and surviving spouses and other dependents of those retired former employees who also claim a right to such benefits, and the surviving spouses of Union-represented Plant employees who died while employed at the Plant who also claim a right to such benefits (the "Class").

Subclass 1: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P&I Agreement dated May 15, 1991 through May 15, 1994, as adopted by the CBA between Goodyear Tire & Rubber Company ("Goodyear") and the Union for the Plant effective November 6, 1991 through November 6, 1994, and as adopted by Shell, and their eligible surviving spouses and dependents.

Hobert Freel Tackett, Woodrow K. Pyles, and Harland B. Conley are all Ohio residents and retirees from the Point Pleasant Polyester Plant in Apple Grove, West Virginia. They and similarly situated retirees belong to a labor union, Plaintiff United Steel, Paper and

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Subclass 2: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P&I Agreement dated July 20, 1994 through July 20, 1997, as adopted by the CBA between Shell and the Union for the Plant effective November 6, 1994 through November 6, 1997, and their eligible spouses and dependents.

Subclass 3: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P&I Agreement dated May 9, 1997 through May 9, 2003, as adopted by the CBA between Shell and the Union for the Plant effective November 6, 1997 through November 6, 2000, and their eligible spouses and dependents.

Subclass 4: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the P&I Agreement dated November 6, 2000 through November 6, 2003, as adopted by the CBA between M&G and the Union for the Plant effective November 6, 2000 through November 6, 2003 and applicable until August 8, 2005, and their eligible spouses and dependents.

Subclass 5: Members of the Class who retired, left service or died while employed at the Plant having met the eligibility requirements for retiree health care benefits specified in the CBA between M&G and the Union for the Plant effective August 9, 2005 through November 6, 2008 or any subsequent CBA between M&G and the Union for the Plant, and their eligible spouses and dependents.

(ECF No. 103, at 2-7.)

Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO-CLC ("USW"), which represented (or at least one of its predecessor unions represented) them as employees of Defendant M&G Polymers USA, LLC ("M&G") (which bought the plant in 2000), or one of its predecessor companies, such as the Shell Chemical Company (which owned the plant from 1992 to 2000) and The Goodyear Tire & Rubber Company (which owned the plant until 1992). Plaintiffs' theory of the case is that the CBA provides vested retiree health care benefits as a result of the following language, which appears in various agreements:

> Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan . . . whose full years of attained age and full years of attained continuous service . . . at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of [health-care] benefits . . . . Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the [health care] benefits . . . . Failure to pay the required medical contribution will result in cancellation of coverage.

In addition to a series of main agreements, a number of side letters are involved in this litigation.

The Sixth Circuit previously explained these documents as follows, before remanding the action to this Court for additional factual development:

> A series of collective bargaining agreements has been in force at the Plant, with each typically lasting around three years before renegotiation. The first letter agreement, signed contemporaneously with the 1991-1994 collective bargaining agreement, was adopted "for purposes of conforming with the new Financial Accounting Standard Board (FASB) accounting requirement" that required accrual accounting of healthcare benefits. This new requirement hurt a company's balance sheet performance if the company had no cap on its health-care costs. While signed in 1991, the caps were not to take effect until July 1, 1997. Concurrent with the 1994-1997 collective bargaining agreement, another cap letter postponed the effective date of the caps to 2004.

Tackett v. M&G Polymers, USA, LLC, 561 F.3d 478, 483 n.1 (6th Cir. 2009).

Plaintiffs claim that on or about January 1, 2007, Defendant M&G acted contrary to the agreements by unilaterally modifying the health care benefits by shifting a large part of the health care costs onto the class members. The other named defendants are M&G-sponsored health plans through which the class members receive health care benefits: the M&G Comprehensive Medical Benefits Program for Employees and Their Dependents, the M&G Catastrophic Medical Plan, the M&G Medical Necessity Benefits Program of Hospital, Surgical,

Medical, and Prescription Drug Benefits for Employees and Their Dependents, and the M&G Major Medical Benefits Plan.

Plaintiffs filed the instant action on behalf of the named retirees and their surviving spouses or dependents, as well as other similarly situated retirees and their surviving spouses or dependents, on February 9, 2007. (ECF No. 1.) Via their amended complaint, Plaintiffs originally asserted three claims: violation of labor agreements, actionable under Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185(a) (Count I); violation of employee welfare benefit plan, actionable under Sections 502(a)(1)(B) and (a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3) (Count II); and breach of fiduciary duty under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (Count III). (ECF No. 14 ¶¶ 26-31.)

Defendants previously filed a motion to dismiss the amended complaint (ECF No. 19), and this Court granted that motion (ECF No. 63). On appeal, the Sixth Circuit Court of Appeals affirmed the dismissal of the § 502(a)(3) claim constituting Count III, but reversed and remanded the remaining Count I § 301 claim and Count II §§ 502(a)(1)(B) and (a)(3) claim (ECF No. 68). Defendants unsuccessfully sought summary judgment on Counts I and II, and the matter progressed to a bench trial held from May 9, 2011, to May 16, 2011.

B. Agreed Facts

The Final Pretrial Order sets forth the parties' agreed facts, providing:

The following facts are established by admissions in the pleadings or by stipulation of counsel:

1. M&G Polymers USA, LLC ("M&G") is a producer of polymer and related chemical products with a facility located in Apple Grove, West Virginia ("the Apple Grove facility," also known as the "Point Pleasant Plant").

2. The Goodyear Tire & Rubber Company ("Goodyear") owned the Apple Grove facility until November 20, 1992, when Shell Chemical Company, an affiliate of Shell Oil Company ("Shell"), purchased it.

3. Production, laboratory, and maintenance employees at the Apple Grove facility are represented by the United Steel, Paper & Forestry, Rubber, Manufacturing, Energy, Allied Industrial & Service Workers International Union, AFL-CIO ("USW") and its Local 644L.

4. Prior to 1995, production, laboratory, and maintenance employees at the Apple Grove facility were represented by the United Rubber Workers ("URW"). The URW merged with the USW in 1995.

5. Retiree Plaintiff Class Representatives H. Freel Tackett, Woodrow Pyles, and Harlan Conley (together with the Class members, the "Retiree Plaintiffs") were employed at the Apple Grove facility and

were members of the collective bargaining unit represented by the Union.

6. Mr. Tackett retired on or about March 1, 1996. Mr. Pyles retired on or about January 1, 1996. Mr. Conley retired on or about August 1, 1998.

7. On November 6, 1991, Goodyear and Local 644 of the URW entered into a collective bargaining agreement ("CBA") effective November 6, 1991 to November 6, 1994.

8. On May 15, 1991, Goodyear and the URW and certain URW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective May 15, 1991 to May 15, 1994 ("1991 Master P&I Agreement").

9. The 1991 Master P&I Agreement between Goodyear and the URW and certain URW locals included a side letter, "Letter G," dated May 15, 1991, dealing with retiree medical benefits ("1991 Letter G").

10. Goodyear created a Summary Plan Description ("SPD") that described the employee benefit programs applicable to hourly rated employees at the Apple Grove facility as of May 15, 1991.

11. Goodyear and Shell entered into an agreement dated December 18, 1992, pertaining to the employment by Shell of certain employees of Goodyear at the

Apple Grove Facility (the "Employee Agreement").

12. On December 29, 1993, Shell formally adopted those Goodyear benefit plans that were previously in effect at Apple Grove for represented employees at the Apple Grove facility.

13. On July 20, 1994, Goodyear and the URW and certain URW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective July 20, 1994 to July 20, 1997 ("1994 Master P&I Agreement")."

14. The 1994 Master P&I Agreement between Goodyear and the URW and certain URW locals contained a side letter, Letter G, dated July 20, 1994 ("1994 Letter G") dealing with retiree medical benefits.

15. On November 6, 1994, Shell and Local 644 of the URW entered into a CBA effective November 6, 1994 to November 6, 1997.

16. On May 9, 1997, Goodyear and the USW and certain USW locals entered into a collectively bargained Pension, Insurance and Service Award Agreement effective May 9, 1997 to May 9, 2003 ("1997 Goodyear Master P&I Agreement").

17. The 1997 Goodyear Master P&I Agreement between Goodyear and the USW and certain USW locals included a

side letter, Letter H, dated May 9, 1997, dealing with retiree medical benefits ("1997 Letter H").

18. On November 6, 1997, Shell and the USW and Local Union 644 entered into a CBA effective November 6, 1997 to November 6, 2000 ("1997 CBA").

19. M&G purchased the Apple Grove facility from Shell effective June 1, 2000.

20. In connection with the purchase, M&G and Shell entered into a Human Resources Agreement dated June 1, 2000 ("HR Agreement").

21. In September 2000, M&G and the USW on behalf of Local 644L began bargaining for a potential extension of the 1997 CBA, which by its terms expired on November 6, 2000, and subsequently engaged in bargaining for a successor to the 1997 CBA.

22. On November 6, 2000, M&G and the USW and Local Union 644L entered into a CBA effective November 6, 2000 through November 6, 2003 ("2000-2003 CBA").

23. In September 2003, M&G and the USW on behalf of Local 644L commenced bargaining for a successor to the 2000-2003 CBA which was due to expire November 6, 2003. This bargaining encompassed more than 60 days of

negotiations from September 2003 through August 2005 (the "2003-2005 Bargaining").

24. On August 9, 2005, M&G and the USW on behalf of Local Union 644L reached agreement on a new CBA effective August 9, 2005 to November 5, 2008 ("2005 CBA").

25. The 2005 CBA included LOU 2003-6, dealing with retiree medical benefits, which was signed by Union chief spokesperson Karen Shipley and Company representative Kimm A. Korber.

(ECF No. 165, at 4-6.)

C. Trial Testimony

In addition to introducing testimony via deposition transcripts, the parties presented live testimony by select witnesses. The Court briefly summarizes the key points of each such witness' testimony below.

1. Woodrow Pyles

Retiree Woodrow Pyles was the first witness to testify. Pyles testified that he had begun working at the Apple Grove facility on May 1, 1959. In December 1992, Shell bought the plant from Goodyear, which Shell later sold to M&G. He retired on January 1, 1996. A union member, Pyles testified that he held a number of positions in the union, including that of union steward and that of liaison. He stated that he would attend P&I conferences and would study the P&I

booklet. After a new pension and insurance agreement ("P&I agreement") had been reached, Pyles testified, the union would hold a conference to explain the changes. He also testified that the local CBA governs working conditions and would be negotiated locally by the union.

Notably, Pyles testified several times that it is the local's position and unwritten policy that letters that are not printed in the booklet distributed to the local union members do not apply to the local union. He stated that no cap letter applied to the Apple Grove agreements. Although he had obtained a copy of Letter G at a conference regarding the 1991 agreement, Pyles testified, he did not distribute the letter to the local members because it was not part of the booklet. Pyles explained that the summary plan description described the plan as non-contributory, with the company paying the entire cost of the plan. He testified that he has not paid union dues since his retirement and that he never gave the union permission to represent him now. Pyles also testified how he has paid the premium for himself and his spouse since its implementation, which he protested in a series of letters to M&G's Kimm Korber that he discussed.

2. Hobert Freel Tackett

Retiree Hobert Freel Tackett testified that he began working at the Apple Grove facility on February 7,1966, and retired from that facility on March 1, 1996. He stated that he had held a number of local union positions, including president and vice-president, and was a member of the local bargaining unit. Similar to Pyles, Tackett identified various agreements and testified that the CBA covers working conditions while

the P&I agreement governs benefits. He testified that he was never aware of any employer contribution limit or cap under the agreement and that he first saw a cap letter only after this litigation had commenced. Tackett testified that he understood the applicable plans to provide retirees who had 95 points with contribution-free medical care for life; they had to pay only if they had less than 95 points. He also testified that he did not believe that letters not printed in the booklet controlled retiree benefits. Tackett stated that he relied on the booklet for medical and pension benefits information. Similar to Pyles, Tackett testified that he had never granted anyone the right to bargain on his behalf since retired.

3. Ron Hoover

Ron Hoover testified next on behalf of Plaintiffs. Hoover explained that prior to his retirement–he is now a union consultant–he worked for the international union with the primary responsibility of working with the master bargaining agreement. He explained that a master bargaining agreement would be negotiated typically every three years, and after that agreement was secured, another agreement would be negotiated in an approach termed "pattern bargaining." Locals would ratify the master agreement and then would negotiate supplemental agreements focused on their specific issues. Not all locals were part of the Goodyear master bargaining, Hoover testified, and Local 644 was not. Some locals not under the master agreement had "me too" agreements in which their own CBA language incorporated some or all of the master agreement provisions. Hoover testified that he believed that the Apple Grove plant stood on its own.

Hoover stated that he was never the lead spokesman at the Apple Grove plant, that the plant was not part of the master agreement, that he was not certain how they even got the pattern agreement, and that he did not know for certain whether Apple Grove adopted the P&I insurance agreement. He also testified that he had never negotiated Local 644 agreements with Shell or M&G. He indicated that he had attended bargaining sessions where benefits had been discussed.

Hoover explained the 1991 cap letter as a union compromise to help Goodyear control or minimize its liabilities; he explained that the letter was a way to avoid showing the extent of projected liability for retiree medical benefits due to FASB considerations. In other words, Hoover explained, the cap letter was a mechanism by which a company could minimize numbers to attract investors. He explained how the letter worked and the importance of what he called the "bite date," or the date on which retirees would have to actually begin contributions toward their medical insurance. Hoover emphasized the importance of always moving the bite date out so that it could always be subject to further movement by negotiation.

According to Hoover, he has no knowledge that the Letter G cap letter was ever adopted at the Apple Grove plant. He explained that the letter was not part of the 1994 agreement between Shell and Local 644. Although he may have participated in 1997 negotiations, Hoover testified, his role was to explain how the Goodyear master agreement worked. Hoover stated that he lacked the authority to bind Local 644 to anything and that only the head negotiator had such

authority. He testified that he did not know whether the cap letter labeled as Letter H automatically applied to M&G. Thus, Hoover testified, when he spoke with Randy Moore, he told Moore that if the cap letter applied, Moore should be certain to move the bite date out so that it did not impact retirees. Hoover also testified that he told Karen Shipley the same thing in 2003. Hoover disagreed with the contention that there was a link between the 95-point rule and the cap letter.

Hoover stated on cross-examination that by agreement not all letters were printed in the booklets. As an example, he explained that the 1991 Letter G was part of the master agreement even though it was not in the printed booklet. Hoover stated that a general understanding existed between the union and company representatives that the bite date would always be moved. He stated that the union never intended to have retirees pay a premium and that he understood that the company representatives could not say publically that there would never be retiree contributions because the accountants would then not certify the FASB statements.

Hoover explained that the Apple Grove plant appeared to be some sort of "me too." He stated that he could not identify well a marked-up copy of the 2000 agreement, and Hoover indicated that he could not say for a fact whether cap letters were part of the adopted agreement. Such letters were not printed in booklets, Hoover again explained. He testified that if the letter information was not presented to the local members, then the local representatives were not doing their jobs. Hoover also testified that a "me too" local could adopt the P&I agreement but not letters and again stated

that he did not know what Local 644 had done. He stated that he did not know whether the letters were ever presented to the local members. Hoover did state that if the cap letters were not renewed, then they were gone. Hoover testified that he had been careful to never interpret the Apple Grove agreement for Local 644.

4. Randall Moore

Randall Moore is currently the Sub-District Director of the international union and was previously a staff representative. He was assigned to Apple Grove negotiations in late summer 2000. Moore testified that he relied on the local committee in these negotiations and explained that after he was unsuccessful at negotiating a two-year extension of the existing agreement, negotiations for a new P&I agreement continued.

Moore testified that based on his experience, the issue of retiree benefits is typically a subject of forward-looking negotiations in which future retirees' benefits are discussed, but existing retiree benefits remain fixed. He stated several times that it was his understanding that Local 644 is a "me too" that accepted only parts of the "Big Rubber" master agreement. Moore stated that, to his knowledge, Shell was not a part of the "Big Rubber" negotiations.

He also testified that the 1997 P&I agreement for the Apple Grove plant did not reference Letter H. Moore stated that when local individuals such as Sam Stewart brought the cap letter to Moore's attention, Moore spoke to Hoover. Hoover provided Moore with a copy of Letter H because the local committee did not

have a copy, Moore testified, and Hoover explained that the cap letter is a FASB accounting letter. Moore testified that Hoover never told him that Letter H applied and only suggested that Moore push back the contribution date if the letter were applicable to Apple Grove. Moore also testified that he looked for and never found any document indicating that Letter H applied.

Moore stated that it was less than clear whether the cap letter applied. He testified that the local committee proposed pushing the effective contribution date out, but that the company denied the proposal. The company was also bewildered by Letter H, Moore explained, and on October 17, 2000, the company's chief negotiator, David Dick, responded to Moore's request for written clarification by providing a document stating the company's position that Letter H did not apply.

Moore also testified that the Apple Grove booklet needed cleaned up because it contained provisions that did not apply to the local plant. He explained that the parties agreed to remove these provisions while abiding by the agreement they had reached. Thus, Moore testified, Letter H was removed, and the 2000 P&I agreement that resulted does not contain Letter H.

He stated that for a period of time, Karen Shipley had been assigned to Local 644 until he was reassigned back to the local. Shipley had asked Moore about Letter H during the subsequent negotiations between the local and M&G, he testified, and Moore explained that Letter H did not apply. Moore testified that he was confused when presented with Letter of Understanding 2003-6 because the union had not

agreed to its contents or that Letter H applied. M&G's new chief negotiator, Robert Long, was given a copy of Dick's October 2000 disavowal of the cap letter's application, Moore testified, but this did not change M&G's position. Moore testified that he stated to M&G in negotiations that he lacked the authority to bargain away benefits for existing retirees.

Moore testified that negotiations over Letter of Understanding 2003-6 went nowhere. He enlisted the aid of the international union's attorney, but the result was still the same. Moore testified that the union saw the handwriting on the wall as to what M&G was going to do, and that when Shipley signed Letter of Understanding 2003-6 on August 9, 2005, it was a simple formality because her name was already on the company-provided signature line. Moore explained that the union knew that future retirees would be covered differently than existing retirees. Although the union contested the lawfulness of M&G's actions, Moore stated, the company went ahead and implemented retiree contributions.

5. Karen Shipley

Karen Shipley is a staff representative for the international. She testified that she was part of the 2003 Apple Grove negotiations and acted as the union's chief negotiator. She therefore had the authority to bind the union, she explained, and that the local committee assists the chief negotiator. After M&G's Long and Korber approached her with Letter H, Shipley spoke with Hoover. The parties disagreed over whether the letter applied, she explained, and she states that she informed the company that the union could not bargain over existing retiree benefits, which

was a permissive subject of bargaining. The union disagreed that Letter H applied, Shipley testified, and took the position that given the company's disagreement, the letter should then be deleted.

Shipley testified that after offering to withdraw Letter of Understanding 2003-6, M&G reversed course and refused such withdrawal. M&G then implemented its last, best, and final offer, she testified, which included Letter of Understanding 2003-6. Shipley testified that the union never agreed to Letter of Understanding 2003-6 while she was negotiating.

6. Brian Wedge

Brian Wedge is currently on leave from the Apple Grove plant while he serves as a staff representative for the international. He testified as to his involvement in numerous Local 644 negotiations in numerous union positions. Throughout the ratification of these agreements, Wedge explained, no cap letters had ever been presented as part of the agreements to be ratified by local members. He discussed the 1997 agreement negotiations specifically and testified that M&G had taken the position that it had separated from the master agreement. M&G's Dick stated that Shell had separated from the master agreement, Wedge testified, because Shell did not belong to the larger negotiating group responsible for that agreement.

In preparing for the 2000 negotiations, Wedge explained, he had heard of Letter H. Because he did not know whether the letter applied or what it was, Wedge testified, he spoke with Hoover and obtained a copy of the letter. Wedge testified that Letter H was not part of the agreement with which they had started.

Since the time he began working at the Apple Grove plant in 1987, Wedge testified, such a cap letter had never been included in the booklets local members received.

Wedge testified that M&G took the position that the cap letter did not apply to M&G or Shell. He also testified that the union regarded the October 2000 Dick document as conclusive. The parties proceeded to adopt the 1997 booklet with some changes, Wedge explained, and produced the actual P&I agreement at a later date. Wedge testified that the parties knew they would have to remove content from the booklet that did not apply to Apple Grove. He stated that this was why he had made a handwritten notation on a union copy of Letter H indicating that the letter was to be removed. Wedge testified that the final copy of the P&I agreement distributed to union members did not contain Letter H.

When he was next part of the negotiating team in 2005, Wedge testified, the cap letter issue arose in conjunction with Letter of Understanding 2003-6. He indicated that Moore had questioned the applicability of a cap letter, and Wedge testified that no retirees had agreed that the union could negotiate benefits on their behalf. Wedge testified that the union attorney had informed the negotiators that the union had no right to bargain for the existing retirees. He repeated that the union was not legally permitted to bargain on behalf of the retirees. Wedge testified that the company nonetheless implemented its plan and that retirees have suffered as a result. Some people, he explained, won't speak to him as a result.

On cross-examination, Wedge testified that the union proposed in 2000 negotiations to move the cap letter effective date of retiree contributions because there was uncertainty over whether the letter applied. He stated that the Dick letter on behalf of M&G resolved the issue and that by the end of negotiations, it was settled that Letter H did not apply.

Wedge also explained the inapplicability of the master agreement. He provided the example of when Moore asserted during negotiations that the master agreement's pension multipliers automatically applied and M&G responded by adopting the position that the master agreement did not control. Wedge also testified that the union was responsible for distributing for local ratification the agreement information. He indicated that there was never an agreement between the company and the union as to what would go into the booklet.

7. Kimm Korber

Defendants' first witness was Kimm Korber, M&G's Human Resources Director. Korber testified that he had been hired in 2001 as Human Resources Manager for the Apple Grove plant and that his duties had included general human resources work as well as labor responsibilities. He stated that he had first become aware of issues with the P&I Agreement in the 2000 negotiations. Korber testified that because the Letter H effective date for contributions was after the next negotiations, he assessed that the letter would be discussed in the 2003 negotiations.

During those negotiations, Korber testified, Shipley had told him that the retiree benefits was a permissive

subject of bargaining, that the parties could not reach an impasse over this issue, and that she was not interested in discussing the issue. He indicated that Shipley had proposed deleting Letter H. He also summarized the history of negotiations, stating that the union changed its position after it learned of Dick's October 2000 document.

Korber testified that he was not trained in benefits administration and that he has only a basic understanding of ERISA requirements. He stated that M&G is the plan sponsor and the named fiduciary, the plan had never sent an ERISA notice to retirees of their being subject to the cap or of the possible termination of benefits.

Korber also testified regarding meeting with Rex Rousch. He denied that Rousch told him that Letter H was a Goodyear document and not a Shell document, but stated that he obtained the letter from Rousch. When presented with various exhibits, Korber indicated that Letter H had not been part of local booklets and could not point to where the 2000 CBA or P&I agreements adopted the Goodyear Letter H.

When questioned regarding the October 2000 Dick response that disavowed cap letter application, Korber testified that he had not discussed the document with Dick. Korber stated that a chief negotiator has the authority to bind a company. When asked whether the union could rely on Dick's response, Korber responded by discussing proposals.

Korber reviewed exhibits related to M&G's acquisition of the Apple Grove facility from Shell and various emails regarding Letter H. He denied that it

was left to counsel to determine the effective date of Letter H, but confirmed that he was part of the decision to apply a cap to all retirees. Korber stated that this was not an actuary decision. He disagreed with the position of Moore and Shipley that they did not have the authority to bargain for retirees, but stated that without Letter H, bargaining for retirees would be a permissive subject of bargaining.

Korber also testified regarding M&G's due diligence in the plant purchase. He further stated that he was aware of Letter H in 2001, although he did not mention the application of caps in a strategy memorandum he wrote on M&G's benefits program. This failure to mention Letter H continued throughout other documents and communications Korber sent involving benefits. In a July 12, 2004 email from Korber to Duane Lee, Korber testified, he did address Letter H, but he denied that this was the first time he sent Lee the letter. Korber testified regarding subsequent emails that noted that Letter H may not be deemed enforceable to Apple Grove and that discussed the possible impact of Letter H. He acknowledged his December 2005 email to Lee that concerned the topic of how much M&G would save if Letter H were applied to all retirees. Korber also acknowledged subsequent emails that tracked the effect of the cap letters, which was that retirees were being dropped from the benefits plan. In subsequent testimony, Korber did not disagree that over half of all retirees had died or been dropped from the benefits plan. In another email that Korber acknowledged, he stated that most retirees look to the booklet for a guide to retirement health plans.

8. Robert Long

The final witness to testify was attorney Robert Long. He explained that he routinely represents management in labor negotiations and that he has participated in between 200 and 300 negotiations. One such negotiation was the Apple Grove bargaining that began in the fall of 2003. He testified that during these negotiations, Shipley stated that the union was not willing to discuss retiree medical benefits and that it was a permissive subject of bargaining. Long testified that generally speaking, retiree bargaining is a permissive, or non-mandatory, subject of bargaining and that a company and union can by mutual agreement enter into agreements on this topic. He later stated that the parties cannot modify vested benefits, but can modify non-vested benefits.

Long testified that following two union caucuses, the union returned to the table and mentioned Letter H, a cap letter, and that Sam Stewart had indicated that it was part of the binding agreement. He stated that no union representative suggested that Letter of Understanding 2003-6 applied only to future retirees. Long testified as to the circumstances surrounding his negotiation offer that, if the union took the position that Letter of Understanding 2003-6 implicated a permissive subject, then the company would withdraw it from the last, best, final offer. He testified that the company ultimately rejected the union's proposal to delete Letter H.

Long also testified that he never did any research as to whether Letter C or Letter H applied, but instead simply accepted the propositions that Shell had adopted Goodyear letters and that M&G had assumed

Shell's contractual obligations. He had been told that M&G had a P&I book with Letters C and H in it. Long testified that he may have seen the Dick response disavowing cap letter applicability, but he stated that he could not recall when. He testified that he relied upon Korber to be the primary architect for P&I proposals and stated that he had never read the 2000 P&I agreement cover to cover and that he did not know whether Letter H was part of that agreement. In subsequent testimony, Long stated that Stewart did not have the authority to bind the union, as opposed to Shipley, who held such authority.

II.

The central issue in this litigation is whether Plaintiffs–the qualifying retirees, their spouses, and their dependants–have a vested right to lifetime, uncapped (or contribution-free) medical benefits. Those plaintiffs in the first four subclasses do. Those plaintiffs in the fifth subclass do not.

This Court begins its discussion with the threshold issue of vesting. The Sixth Circuit has held that "[r]etiree health benefit plans . . . are welfare benefit plans; thus, vesting only occurs if the parties so intended when they executed the applicable labor agreements." *Noe v. PolyOne Corp.*, 520 F.3d 548, 552 (6th Cir. 2008). See also *Tackett*, 561 F.3d at 489. The presence or absence of such intent is critical here because, as the court of appeals has explained, "[i]f the parties do not intend to vest the benefits, the former employer can modify the retiree benefits without breaching a collective bargaining agreement." *Tackett*, 561 F.3d at 489. The appellate court has also explained that "[a] court may find vested rights 'under

a CBA even if the intent to vest has not been explicitly set out in the agreement.'" *Id.* (quoting *Maurer v. Joy Technologies, Inc.*, 212 F.3d 907, 915 (6th Cir. 2000).

The Sixth Circuit has described the "broad analytical framework" that this Court must apply to the vesting issue as follows:

> The seminal case for determining whether the parties to a CBA intended benefits to vest is *UAW v. Yard-Man*, 716 F.2d 1476, 1479 (6th Cir. 1983). Under *Yard-Man,* basic rules of contract interpretation apply, meaning that courts must first examine the CBA language for clear manifestations of an intent to vest. *Id.* Furthermore, each provision of the CBA is to be construed consistently with the entire CBA and "the relative positions and purposes of the parties." *Id.* The terms of the CBA should be interpreted so as to avoid illusory promises and superfluous provisions. *Id.* at 1480. Our decision in *Yard-Man* also explained that "retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference . . . that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." *Id.* at 1482. With regard to the "*Yard-Man* inference," later decisions of this court have clarified that *Yard-Man* does not create a legal presumption that retiree benefits are interminable. *Yolton*, 435 F.3d at 579. Rather, *Yard-Man* is properly understood as creating an inference only if the context and other available evidence indicate an intent to vest. *Id.*

> When an ambiguity exists in the provisions of the CBA, then resort to extrinsic evidence may be had to ascertain whether the parties intended for the benefits to vest. *Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am. v. BVR Liquidating, Inc.*, 190 F.3d 768, 774 (6th Cir. 1999). If an examination of the available extrinsic evidence fails to conclusively resolve the issue and a question of intent remains, then summary judgment is improper. *Int'l Union, United Mine Workers of Am. v. Apogee Coal Co.*, 330 F.3d 740, 744 (6th Cir. 2003).

Noe, 520 F.3d at 552. The court of appeals has further clarified:

> Courts reviewing a collective bargaining agreement must also keep in mind the context of labor-management negotiations on retiree health-care benefits: "because retirement health care benefits are not mandatory or required to be included in an agreement, and because they are 'typically understood as a form of delayed compensation or reward for past services' it is unlikely that they would be 'left to the contingencies of future negotiations.'" *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 580 (6th Cir. 2006) (quoting *Yard-Man*, 716 F.2d at 1481-82).

Tackett, 561 F.3d at 489. Application of these directions to this case has led this Court to the conclusion that Plaintiffs obtained vested medical benefits.

This conclusions does not conflict with the Sixth Circuit's prior discussion of the issue of vesting. Citing the November 6, 2000 CBA language set forth above, the court of appeals previously made several critical points:

> First, the "full Company contribution" language suggests that the parties intended the employer to cover the full cost of health-care benefits for those employees meeting the age and term-of-service requirements. Keeping in mind the context of the labor-management negotiations identified in *Yard-Man*, we find it unlikely that Plaintiff USW would agree to language that ensures its members a "full Company contribution," if the company could unilaterally change the level of contribution. The CBA has no limitation on the amount of a company contribution and if the Defendants' argument were accepted, the company presumably could lower the contribution to zero without violating this language. Such a promise would be illusory.
>
> Second, the limiting language, "[e]mployees will be required to pay the balance of the health care contribution," follows the provision requiring contributions by those retirees who had not attained the requisite seniority points. From the placement of this language, we can reasonably infer that it did not apply to all retirees, but only to those retirees who had not attained the requisite seniority points.
>
> Third, the collective bargaining agreement tied eligibility for health-care benefits to pension

> benefits. This is another factor indicating that the parties intended the health care benefits to vest upon retirement.

Tackett, 561 F.3d at 490. This Court previously noted that, on its face, the court of appeals' language appears to present a controlling interpretation of the CBA that proves dispositive of at least the vesting issue, if not the issue of capped versus uncapped benefits.

This Court has recognized, however, that the next sentence of the court of appeals' opinion suggests that perhaps the Sixth Circuit was not handing down an opinion that proves dispositive outside the Rule 12 context. Following the third point, the *Tackett* panel stated that "[w]e hold that the Plaintiffs' Complaint presented a plausible claim that the parties intended to vest health-care benefits. Accordingly, we hold that the district court erred in granting the Defendants' Rule 12(b)(6) motion on the § 301 claim." *Id.* This language might cast the otherwise essentially conclusory language of the three points (noting that the appeals court did use some qualified language such as "suggests") into a qualified light and presents the issue of whether the Sixth Circuit was interpreting the language as a matter of law or simply saying that it presented a plausible claim for Rule 12(b)(6) purposes and that the vesting issue was left open upon remand.

This Court continues to find the answer to the vesting issue in the next portion of the appellate decision. There, the *Tackett* panel moved from Count I, the § 301 claim, to Count II, the § 502(a)(1)(B) claim. After outlining the considerations relevant to deciding the vesting issue, the Sixth Circuit stated that "[t]he determination above that *the parties intended health-*

care benefits to vest carries over to the ERISA § 502(a)(1)(B) claim. The Plaintiffs have therefore presented a plausible claim under ERISA § 501(a)(1)(B)." *Tackett*, 561 F.3d at 490 (emphasis added). Notably, the court of appeals phrased its summary of its prior discussion as an unqualified declaration–"the parties intended health-care benefits to vest"–without linking that summary statement to a mere finding of a plausible claim. By presenting the intended vesting as a fact leading to the result that Plaintiffs had presented a plausible claim, the appellate court pointedly issued a conclusion instead of merely recognizing a credible possibility.

In other words, had the Sixth Circuit said that based on the factual allegations that it must accept as true, it concludes that Plaintiffs have stated a plausible claim for Rule 12(b)(6) purposes, this Court would perhaps consider the vesting issue open on remand. But what the court of appeals did was conclude that the parties intended vesting, which meant that Plaintiffs had of course stated a plausible claim, which meant that they should have survived the Rule 12(b)(6) attack. The distinction is important; it is the difference between saying that the facts *likely* present a viable claim and saying that the facts *do* present a viable claim. This Court therefore stands by its prior conclusion that the Sixth Circuit answered the threshold vesting issue.

Even if this Court is incorrect in its interpretation of the appellate precedent and the court of appeals did not intend to be dispositive on the issue and reasonably only intended to reach the issue of plausibility of the claim presented, the Court again recognizes that there

are no facts that would defeat the same conclusions. The linking of eligibility for health care benefits to pension benefits indicates the parties' intent that health care benefits vested upon retirement. *See Reese v. CNH America LLC*, 574 F.3d 315, 322 (6th Cir. 2009) (noting cases in which the tying of eligibility for pension benefits to eligibility for health-care benefits "played a 'key' role in a vesting-of-health-benefits determination").

Regardless of the analytic path, the end result is still the same because, in light of the meaning of the CBA language, this Court must conclude that vesting occurred. Whether the appellate path or this Court' own analysis leads to this conclusion is ultimately irrelevant. What is significant is that the Sixth Circuit did not conclusively state the precise nature of the right to health care benefits that vested in light of the fact that the appellate panel left the door open for further related factual development and analysis on remand. After summarizing the cap letters and the postponement of the effect date of the caps, the Sixth Circuit stated that "[t]he import of this perpetual postponement and the applicability of these cap letters to the current parties are fact issues that must be resolved by the district court outside of the Rule 12(b)(1) determination." *Tackett*, 561 F.3d at 482 n.1. Thus, as in *Reese*, the core issue in this case is ultimately not "did the benefits 'vest,' " but rather "what does vesting mean in this context." *Reese*, 574 F.3d at 321. The bench trial answered *what* vested.

What vested for those plaintiffs in Subclasses One through Four was a right to contribution-free lifetime health benefits. What vested for those plaintiffs in

Subclass Five was a right to capped lifetime health benefits, contingent on the qualifying plaintiffs paying the above-cap premiums.

While disagreeing with the Court's vesting analysis, Defendants have taken the position that the health care benefits agreements condition exercise of any vested right to benefits on satisfaction of the cost-sharing precondition. Defendants' theory of the case is that there has been continuity in the wholesale assumption of contractual obligations by each owner of the Apple Grove plant, an unbroken line of side agreements that provide contextual meaning to the language of the main agreements. They posit that the side agreements apply to the plant and its retirees either expressly or under a "me too" arrangement. Thus, Defendants reason, the right to the contingent benefits is clear provided a retiree satisfies the condition of making his or her contribution. This is a permissible scheme; a plan may contemplate fully funded, lifetime health care benefits *or* defined-contribution health care benefits. *Wood v. Detroit Diesel Corp.*, 607 F.3d 427, 432 (6th Cir. 2010). The scheme Defendants assert is not, however, the scheme that exists here.

The factual history that the parties present could not be more different. On one side, Defendants have presented largely dubious testimony to support the theory that an unbroken chain of cap letters informs agreements resulting in at most lifetime health care benefits that are contingent on satisfaction of a cost-sharing arrangement. On the other side, Plaintiffs have presented notably more compelling evidence that Defendants have engaged in after-the-fact company

scrambling to find a way to impose unilaterally application of cap letters as a costsavings measure that defies the agreements the caps puncture.

This Court has untangled which agreements do in fact apply to the Apple Grove plant and concludes that Defendants have conflated companies and agreements. The pre-August 5, 2005 side agreements to the master agreements do not apply to Apple Grove. Rather, the intent and effect of the applicable operative documents governing Subclasses One through Four present a lifetime benefits scheme for qualifying retirees and beneficiaries without the cost-sharing Defendants wrongly imposed. The cap letters were not part of these agreements, and even if they were, they were wholly abandoned.

Thus, contrary to Defendants' assertions, there is no unbroken chain of cap letter applicability. The evidence indicates that Apple Grove is a partial "me too" plant, or a "me too, with exceptions" plant, with the ability to accept or reject such side agreements. The evidence also indicates that Local 644 rejected application of these unpublished agreements. Additionally, chief company negotiator Dick expressly rejected cap letter applicability, and when union negotiator Moore attempted to pull a master agreement's pension multipliers into the negotiation, M&G took the position that the master agreement did not control–a position that undercuts reliance on side agreements that the evidence indicates ultimately applied only to the master agreements.

The first cap letter at issue was in 1991. The evidence does not support that this letter was part of the P&I booklet adopted by Local 644. Testimony

indicated that the booklets are prepared after the local's vote. There is no testimony that the agreement terms ratified by the local included cap letters, regardless of the subsequent booklet content. The testimony of Wedge, Moore, Hoover, Pyles, and Tackett indicates that the booklet as published set forth the total benefits agreement and that it was both permissible and the unwritten policy and practice of Local 644 to adhere to only that which was published in the booklet. Pyles did not testify to knowledge of a cap obtained from a summary plan description; rather, he testified that he did not know of the cap letter and consequently did not ratify it as part of the local agreement. Hoover made clear that a "me too" local could indeed decline to adopt the side agreement letters, and the testimony of Pyles of Tackett indicate that this was the unwritten policy and practice of Local 644. Even James Kruse, whose deposition testimony generally weighed against Plaintiffs in many respects, recognized the divergent nature of the Apple Grove plant. Absent cap letter incorporation into the local P&I agreement, Shell (and consequently, M&G) could not have assumed the cap letter agreement as a successor as part of its purchase of the plant. There is no basis to conclude that the 1991 summary plan description was presented to local members; in any event, a summary cannot itself constitute the terms of the agreement for § 502(a)(1)(B) purposes. Additionally, as Joint Exhibit No. 2 reflects, the express incorporation of specified Goodyear agreements did not include all Goodyear side agreements, pointing to the conclusion that Shell never initially adopted a cap letter.

Neither the 1994 nor 1997 dealings implemented cap letter applicability to the Apple Grove facility. Although deposition testimony by Dale Wunder supports adoption of Letter H in 1997, this conflicts with the Shell documentary evidence and the more credible testimony of Local 644 members as to what they saw, what they ratified, and how the local approached the incorporation issue. The cap letters at issue were Goodyear cap letters that were not negotiated into the local P&I agreements.

The Court also notes expressly that the evidence concerning the 1997 agreement working copy is not the smoking guns Defendants contend. Instead, as Plaintiffs accurately targeted during trial, this was a Goodyear agreement signed by Goodyear officials who were unable to sign for Shell. The working copy cannot provide a logical basis for cap letter incorporation because when placed in context it is apparent that it was simply that: a copy of an agreement from which the parties could begin their work, with not all parts applicable to the relevant negotiating parties.

In 2000, when Shell sold the Apple Grove plant to M&G, M&G assumed CBA and P&I agreement obligations from Shell. The company's own accountants recognized the retiree benefits as involving no retiree contribution, and there was no booklet incorporation of the cap letter.

It is significant that even if there were at one point cap letter applicability for pre-August 5, 2005 retirees, the parties' dealings extinguished invocation of such retiree contributions. At one point, the union took the position in negotiations that the cap issue was at least potentially relevant, and the union's negotiator

recognized the potential applicability of the cap letter. Testimony explained the prophylactic context of Moore's actions and points to strategic maneuvering that removed any possibility of cap letter applicability. M&G disavowed cap letter applications, the effective contribution date of the relevant hypothetically applicable cap letter expired, and the parties proceeded without the possibility retiree contributions for existing retirees. Even assuming *arguendo* earlier cap letter applicability, the 2000 P&I agreement cut off any chain of cap letters.

Letter of Understanding 2003-6, dated August 9, 2005, and made part of the 2005-2008 agreement that applies to those plaintiffs in Subclass Five, permits implementation of above-cap retiree contributions. The issue is whether that document looks only forward from August 9, 2005, or indeed presents a permissible, memorialized understanding of existing if previously unimplemented side agreements. Defendants would have this Court accept the proposition that the parties continually kicked the can of retiree contributions down the road until it was no longer economically feasible for the company. The evidence is to the contrary.

Letter of Understanding 2003-6 contemplates caps on employer contributions to retiree health benefits and provides that "premium cost sharing charged to retirees will be based on the amount by which total cost for all retiree insurances (medical, life, etc.) exceed the caps set forth in Letter H dated January 1, 2001." The unilaterally implemented letter also states that retirees would not be required to contribute to their premiums until January 1, 2006, and that the retiree

premium contribution rates would become effective on that date. Defendants argue that Letter of Understanding 2003-6 and the union's history of attempting to negotiate the effective date of caps and to eliminate the application of Letter H point to the application of the caps to M&G. Defendants posit that Letter of Understanding 2003-6 unambiguously supports the unbroken application of caps to retirees (including preexisting retirees). That document explicitly references the prior 2001 cap letter and provides that "[r]etiree benefits" means "benefits for the Company's preexisting retirees." The trial testimony undercuts deeming Letter of Understanding 2003-6 dispositive in Defendants' favor for pre-August 9, 2005 retirees, spouses, and dependents.

This Court concludes that Letter of Understanding 2003-6 does not rehabilitate broken or reaffirm longstanding cap letter applicability in regard to those plaintiffs in Subclasses One through Four. Despite Defendants' best efforts at rewriting history, the trial evidence places the previously ambiguous Letter of Understanding 2003-6 into its proper context as a going-forward document applicable to individuals in Subclass Five and not a document that also speaks to and clarifies the meaning of the prior agreements governing Subclasses One though Four. The actual context of Letter of Understanding 2003-6 does not include a shared intent to vest only partially funded (*i.e.*, capped employer contributions for) lifetime health care benefits to retirees in the first four subclasses. Rather, the document's context teaches this Court that application of Letter of Understanding 2003-6 to the plaintiffs in the first four subclasses was a unilateral move by M&G to unlawfully circumvent binding

agreements to obtain economic advantages. The addition of Letter of Understanding 2003-6 to the 2005-2008 agreement changes the meaning of what constitutes a "full company contribution" from prior agreements so that the clause no longer means the full cost of health-care benefits for qualifying employees, but rather a capped company contribution to the health-care benefits.

To be certain, the parties' decade-plus history of dealing with the cap letters and contributions does not present a model of negotiating clarity, much less competence. On one side, the union's own negotiator once questioned cap letter application, and at least one if not more Local 644 individuals who lacked binding authority appeared not to understand what was involved in the negotiations and the agreements reached. The companies fare no better. During the 2000 CBA negotiations, attorney David Dick was the lead or chief negotiator for M&G and stated clearly and unequivocally that the cap letter did not apply. The testimony Defendants intend to explain away Dick's purported "confusion" is simply not credible.

Nor is the testimony of Long helpful in regard to applicability. The curiously under-informed Long expressly relied on Korber, whose testimony this Court found to be incredible time and again, in accepting cap letter applicability. Having had ample opportunity to observe the witness and to consider his testimony, this Court expressly rejects as simply not credible the testimony of Korber, M&G's Human Resources Director, which indicated that M&G had assumed cap letters as part of the preexisting obligations as a successor to Shell. Korber's actions, particularly his

communications with the consultant actuaries for M&G, are not consistent with an individual or a company that knew or believed that any cap letter applied. It does not appear to this Court that Korber knew of Letter H until at least 2003, despite his contention that he knew of the cap letter years earlier. Additionally, M&G's own reporting of contribution-free retiree health care benefits (tracking Shell) contradicts the company's post-hoc position that the cap letters always applied and undercuts Korber's self-serving testimony.

In contrast to Korber's testimony, the Court found credible the testimony of Hoover and Moore, who together explained that confusion existed because various locals had different approaches. Potential cap letter application does not equal actual application, and the Court finds that Local 644 never adopted cap letters prior to August 9, 2005, even if union leadership was uncertain about that position at times and had to check in with the home office for assistance during negotiations.

It is also notable that the union lacked the ability to negotiate the vested retiree benefits. Pyles and Tackett, for example, did not consent to the parties addressing this permissive subject of bargaining. There is no evidence any retiree did. But there is evidence that union negotiators such as Shipley routinely adopted the position that retiree contributions were not on the table. Only individual union members not in the know apparently believed that the cap letters applied, and they lacked authority to bind the union and the retirees.

As the Court has previously noted, the significant confusion by the parties is odd. It appears that various individuals' efforts to circumvent clarity and full disclosure to the public of self-serving arrangements got a bit too clever for nearly all involved until even key actors were confused by what essentially hidden agreements applied in what context. Goodyear master agreement shenanigans did not necessarily filter down to the me too with exceptions plant involved here, but the various actors in the history of the Apple Grove plant appear to have been rarely well informed. This is no way to run a business or a union. Companies should know what they are buying (obligations and all), investors should know what company liabilities exist, unions at all levels should be clear on what they are negotiating, and retirees should know what agreements they are ratifying.

Plaintiffs have presented ample evidence involving M&G's counsel, actuaries, and human resources personnel that no one thought that there was a cost-sharing plan in place for Apple Grove retirees for years until it became advantageous to the company. Multiple M&G actors appear at best uncertain of what benefits liabilities they assumed when they purchased the plant and another expressed a position wholly adverse to cap letter applicability. Those who testified supporting cap letter applicability wholly lacked veracity. Ultimately, this litigation presents a scenario in which a company faced with ballooning benefits costs uncovered a longshot means by which it could attempt to retroactively rewrite agreements to reduce costs–and then the company turned to actuaries to inform the purported scope of the cap letter, apparently basing the claimed scope on the amount of money that

could be saved if the company prevailed. This is unlawful.

The issue of liability that once appeared complicated during summary judgment proceedings became far more clear as a result of the trial. And despite real conflicts in evidence, including each party's own at times contradictory evidence, the greater weight of the evidence favors Plaintiffs. For example, the evidence indicates that Dick, the company's chief negotiator and someone with the clear authority to bind the company, rejected cap letter applicability. The company attempts to insulate itself by dubiously disowning his comments and authority, while concurrently pointing to Long's testimony as supporting applicability. Defendants cannot reject one of their negotiators as misinformed and turn to another uninformed negotiator to achieve the continuity of applicability that they seek to prove.

In contrast, the evidence indicates that those with the authority to bind the union disputed cap letter applicability. The company insists that the Court should credit instead those local members who lacked such binding authority. The evidence indicates that there were no ERISA notices given here, that the retiree benefits issue was not a subject of bargaining, and that the retirees did not consent to negotiations on the issue. The company asks this Court to ignore these facts. The evidence indicates, however, that Defendants developed the contribution scheme as a self-serving response to economic realities and in contravention of the negotiations conducted and applicable agreement reached. This is impermissible under the controlling law.

The plan participants' understanding of what they ratified reflects the benefits agreements reached. This Court concludes: (1) the relevant agreements set forth a scheme in which the employer is responsible for covering the full cost of health-care benefits for those employees meeting the age and term-of-service requirements in Subclasses One through Four; (2) qualifying individuals in Subclasses One through Four are entitled for the company to cover the full cost of the health benefits, without these plaintiffs being required to pay premium contributions; (3) the contribution-free health benefits for individuals in Subclasses One through Four exist despite the fact that various inapplicable side agreements between other parties deferred the eventual collection of retiree contributions; (4) for the plaintiffs in Subclasses One through Four, Defendants have had no right to collect the premiums charged and have impermissibly terminated benefits for the failure to make such a contribution; and (5) the cap letter applied to Subclass Five, the members of which Defendants could permissibly require to make above-cap contributions.

Having determined both that vesting occurred and what vested, this Court is left with the issue of whether the scheme of permissible contributions governing Subclass Five is nonetheless unlawful in its execution. The Subclass Five Plaintiffs claim that Defendants cannot charge the monthly contributions because they have the effect of forcing retirees out of the benefits plan. Defendants argue in turn that the monthly premiums are acceptable under the negotiated 2005-2008 agreement. Defendants are correct.

The evidence supports that the 95-point agreement language does not preclude retiree contributions for those individuals qualifying for health benefits post-August 9, 2005. The 95-point language itself would not preclude retiree contributions for pre-August 9, 2005 retirees; it is only the inapplicability of the cap letters prior to August 9, 2005 that defeats such a scheme here.

Korber testified that the contribution plan that M&G presented to the union involved monthly premiums, derived from the average above-cap cost, and he did not recall any objection to the monthly basis calculations other than counter-proposals. The Court credits this testimony. Although Korber's testimony regarding the application of cap letters to all retirees was largely not credible, his essentially uncontradicted testimony regarding monthly premiums was more persuasive. Korber explained how application of the methodology set forth in Letter H in conjunction with Letter of Understanding 2003-6 to the actual claims data produced the monthly-premium information provided to the retirees prior to the effective date of retiree contributions. (Defs. Ex. 152.)

The Court understands Plaintiffs' frustration with the monthly costs, which will likely only increase as time passes and no doubt can impose a substantial burden on the affected retirees. Such monthly premiums are not a surprise. Letter H speaks in terms of annual costs and averages, but the evidence indicates the understanding that the annual costs would be broken into monthly payments. Hoover testified that monthly premiums were contemplated by Kruse under the Goodyear cap letters, the model for

the cap letter governing Subclass Five. Hoover also testified that he did not know how a health benefits premium would be paid otherwise and that such an approach made sense. Such a monthly premium approach was incorporated into the union-M&G discussions over retiree contributions, with *both* sides making 2006 proposals involving monthly contributions. The resulting approach is what became part of the 2005-2008 agreement, and the effects of that agreement are the results of the parties' negotiations. Defendants are thus within their contractual rights in imposing the monthly premiums imposed, however harsh the result may be. Because the calculations and monthly premiums are in accord with the negotiated agreement for those plaintiffs in Subclass Five, Defendants are entitled to judgment on this subclass' claims.

III.

In light of the foregoing findings of fact and conclusions of law, the Court finds in favor of Plaintiffs in Subclasses One through Four and against Defendants on the issue of liability as described herein on Plaintiffs' Count I and II claims. The Court finds in favor of Defendants and against Plaintiffs in Subclass Five on these claims. This leaves the issue of damages, which the Court previously bifurcated from the liability issue. (ECF No. 166.) The Court shall schedule a telephone status conference to set a case schedule on the remaining issues in this litigation.

There being no just cause for delay, the Clerk shall enter judgment in accordance with this Opinion and Order.

IT IS SO ORDERED.

/s/ Gregory L. Frost
GREGORY L. FROST
UNITED STATES DISTRICT JUDGE

REPLY BRIEF

RECORD AND BRIEFS

No. 13-1010

In The
Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

REPLY IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

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TABLE OF CONTENTS

		Page
I.	A Circuit Split Regarding The *Yard-Man* Presumption Is Evident	2
II.	The Sixth Circuit's Resolution Of The Purely Legal Issues Presented Here Was Outcome Determinative	7
III.	Respondents Do Not Dispute The Existence Of A Related But Distinct Circuit Split	10
CONCLUSION		11

TABLE OF AUTHORITIES

Page

CASES

Golden v. *Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996) 9

Joyce v. *Curtiss-Wright Corp.*, 171 F.3d 130 (2d Cir. 1999) 6

Litton Fin. Printing Div. v. *NLRB*, 501 U.S. 190 (1991) 4

Maurer v. *Joy Techs., Inc.*, 212 F.3d 907 (6th Cir. 2000) 5

Reese v. *CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) 1, 3, 9

Rossetto v. *Pabst Brewing Co.*, 217 F.3d 539 (7th Cir. 2000) 5, 6, 11

UAW v. *Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999) 6

Yolton v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006) 9

REPLY BRIEF FOR PETITIONERS

As it has done in other cases, the Sixth Circuit "inferred" here that the context of retiree benefits meant the parties intended the medical benefits at issue to vest. That determination—the key issue in the case—took place long before any factfinding or credibility determinations by the trial court. It was an outcome-determinative holding decided solely on the basis of language in the collective bargaining agreement. But had the case arisen in another circuit, the district court's original determination against vesting would have been upheld and the trial would have never taken place.

Judges and academics alike have long speculated about when this Court might decide the questions presented and put an end to the Sixth Circuit's a-textual (and unwarranted) *Yard-Man* doctrine. Respondents stand with the Sixth Circuit in disavowing its effects but, as Judge Sutton has noted, *Yard-Man* "must mean something or else there would be no point in having it." *Reese* v. *CNH Am. LLC*, 574 F.3d 315, 321 (6th Cir. 2009).

This case is an ideal vehicle for restoring uniformity on a recurring issue that will only increase in importance over the coming years as health-care regimes become increasingly complicated. Contrary to respondents' attempt to obscure it, the issues before this Court are ones of pure law—i.e., determining the role contractual silence should play in evidencing an intent to vest health-care benefits in collective bargaining agreements (and relatedly,

whether a different interpretive rule should apply in the collective-bargaining context than in the ERISA context). Unlike previous petitions, those issues of pure law are squarely presented here in a final judgment and, respondents' overheated rhetoric aside, can be resolved by this Court without any incursion into the fact-finding province of the district courts.

The Court should grant M&G's petition, reverse the Sixth Circuit, and restore uniformity on the exceedingly important question of how to read collective bargaining agreements to determine whether retiree health-care benefits have vested.

I. A Circuit Split Regarding The *Yard-Man* Presumption Is Evident

Respondents recognize that, in the retiree health-care benefits context, "traditional contract-interpretation rules" are "refined by * * * nuanced, Sixth Circuit jurisprudence." Opp. 9. The word "nuanced" may never have carried more weight. Indeed, if *Yard-Man* were truly as innocuous as respondents would have it, there would be little point for the Sixth Circuit to deploy it each time it is faced with a case regarding retiree health-care benefits in collective bargaining agreements. As the petition explained (at 10-11), the attempts of various Sixth Circuit panels to downplay the effect the presumption has on "normal contract interpretation principles" only underscore the Sixth Circuit's wrong turn away from those principles. Indeed, the circuit split on this issue could not be clearer.

To begin, as demonstrated in the petition (at 10-17), the difference between the Sixth Circuit and others—such as the Second, Third, and Seventh—is stark and evident in the case law. Commentators both in favor of and opposed to *Yard-Man* openly acknowledge that the doctrine alters the calculus in the Sixth Circuit. See, e.g., Pet. 12 (citing commentators). And the case at bar shows why the split matters to employers dealing with an increasingly complicated health-care system and faced with entirely different outcomes depending on where a case is brought. See Pet. 22-25.

A. Contrary to respondents' repeated claims, the Sixth Circuit's *Yard-Man* doctrine is no insignificant matter of garden-variety contract interpretation. As the Sixth Circuit explained in this very case, "[c]ourts reviewing a collective bargaining agreement must also keep in mind the context of labor-management negotiations on retiree health-care benefits." Pet. App. 110.

In the Sixth Circuit, however, "context" has subsumed "text"—and turned the rules of ordinary contrary interpretation on their heads when it comes to collective bargaining agreements. The Sixth Circuit's a-textual approach thus allows extrinsic evidence to make its way into the determination from the outset: a practice plainly contrary to the normal rules of contract interpretation. See *Reese*, 574 F.3d at 321 ("Although we do not apply a 'legal presumption that benefits vest' and although we require plaintiffs to bear the burden of proving that vesting

has occurred, we apply an 'inference' that 'it is unlikely that [welfare benefits] would be left to the contingencies of future negotiations,' so long as we can find either 'explicit contractual language *or* extrinsic evidence indicating' an intent to vest benefits." (alteration in original) (emphasis added)).

In overturning the district court's initial ruling in favor of petitioners, the Sixth Circuit panel relied on the "*context* of the labor-management negotiations identified in *Yard-Man*" to "find it unlikely" that the union would have agreed to non-vested health-care benefits. Pet. App. 112 (emphasis added). Though it is undisputed that the agreement was silent on the vesting question, and it is undisputed that the union is a sophisticated party that could have inserted unambiguous vesting language if that is what it wanted, the panel "inferred" vesting based solely on the promise of a "full Company contribution."

The panel next "inferred" vesting from the placement of the vesting language in the contract. It followed the provision that required certain employees to make contributions to the health-care costs. This led the panel to believe that those who did not have to contribute were thus vested with the benefits. Pet. App. 112. But the panel—and now respondents—ignore that collective bargaining agreements expire with the termination of the agreement. *Litton Fin. Printing Div.* v. *NLRB*, 501 U.S. 190, 207 (1991). So just because a "full Company contribution" is promised in a collective bargaining agreement does

not mean it is vested beyond the life of that agreement.

Finally, the panel noted that the collective bargaining agreement "tied eligibility for health-care benefits to pension benefits" and treated that as a factor indicating that vesting was intended. Pet. App. 112. And so from silence, the panel inferred that petitioners really meant for the benefits to live beyond the collective bargaining agreement itself. That result follows directly and inexorably from *Yard-Man*. Pet. App. 113-14 ("When the plan document at issue is a collective bargaining agreement, the interpretative principles outlined in *Yard-Man* govern a court's determination of the parties' intent to vest health-care benefits." (citing, as Judge Posner did, *Maurer* v. *Joy Techs., Inc.*, 212 F.3d 907, 917 (6th Cir. 2000))).

The *Yard-Man* presumption—or inference, the difference is mere semantics—is thus fundamentally at odds with the basic rules of contract interpretation correctly followed by other circuits.

B. In the lower courts, retiree health-care benefit cases truly "are all over the lot. Some presume vesting. Some insist that there be express language to that effect. Some presume nothing." *Rossetto* v. *Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000) (citations omitted). Even more important than Judge Posner's apt description of that sorry state of affairs—a description that easily withstands respondents' feeble attempt to discredit it—is the holding set forth by the Seventh Circuit in that case.

The Seventh Circuit recognized a "presumption *against* vesting" that "kicks in only if all the court has to go on is silence." *Id.* at 544 (emphasis added). This presumption "enables the employer to fend off a trial without having thought to have included in the contract an express provision limiting the duration of the benefits." *Ibid.* Even if one is inclined to agree with *Yard-Man*, as respondents plainly do, this holding evidences a direct circuit conflict on the precise question presented here.

But other cases evidence the circuit split as well, and respondents cannot deny the existence of that split merely by insisting that the courts on the other side of it are wrong. See, e.g., Opp. 17 (discussing *UAW* v. *Skinner Engine Co.*, 188 F.3d 130, 139-41 (3d Cir. 1999) (panel including then-Judge Alito) (rejecting *Yard-Man*)). And respondents do not even address the Second Circuit's explicit rejection of *Yard-Man*. Pet. 15-16 (citing *Joyce* v. *Curtiss-Wright Corp.*, 171 F.3d 130, 134-35 (2d Cir. 1999) (panel including then-Judge Sotomayor)). If anything, respondents' merits-based arguments only confirm the existence of a split that has been explicitly recognized by courts and commentators alike. See Pet. 10-17.

C. Respondents attempt to downplay the split (and the importance of resolving it) by pointing out that employers sometimes manage to win even in the Sixth Circuit. Opp. 9, 17. But as the commentators cited in the petition (at 12 & n.2) have explained, the difference in outcomes in the two circuits with the

most diametrically opposed approaches to the vesting question—the Sixth and the Seventh—speaks for itself, as employers win only 11 percent of the time in the Sixth Circuit versus almost 80 percent of the time in the Seventh Circuit on this issue. Even those who approve of the Sixth Circuit's approach recognize the presumption in favor of vesting. *Id.* at 11. It cannot be credibly maintained that the circuits are not deeply divided on the question of retiree health-care benefit interpretation.

II. The Sixth Circuit's Resolution Of The Purely Legal Issues Presented Here Was Outcome Determinative

This case turned on the Sixth Circuit panel's decision in *Tackett I*—based on the *Yard-Man* presumption—that the benefits were vested as a matter of law. Pet. App. 114. Indeed, the district court initially dismissed all of respondents' claims given the undisputed evidence of cap agreements in place concerning the health-care benefits. In *Tackett I*, however, the Sixth Circuit used *Yard-Man* to tie the district court's hands. Pet. App. 90. Although respondents are correct that credibility determinations were made in their favor later in the proceedings, those determinations are irrelevant to the questions presented here. By that point in the proceedings, only the question of *what* vested was left for the district court to answer. *Id.* at 64.

The district court did not establish the vesting of benefits—that question was decided for it by the Sixth Circuit in its first panel opinion, when it held, contra other circuits, that "[a] court may find vested rights under a [collective bargaining agreement] even if the intent to vest has not been explicitly set out in the agreement." Pet. App. 58 (citation and internal quotation marks omitted). As the Sixth Circuit itself recognized, the interlocutory panel holding established "a controlling interpretation of the [collective bargaining agreement] that prove[d] dispositive of at least the vesting issue, if not the issue of capped versus uncapped benefits." *Id.* at 61. Though the Sixth Circuit paid lip service to not deciding the ultimate question, *id.* at 61-62, its summary of the agreement at issue was "an unqualified declaration" that "'the parties intended health-care benefits to vest.'" *Id.* at 62. The district court thus eventually made factual findings that aligned with its "conclusion that the Sixth Circuit answered the threshold vesting issue." *Id.* at 63.

But the collective bargaining agreement at issue here was silent on that "threshold" issue—and typically, when an agreement expires, its provisions do not outlive it. One may agree or disagree with the wisdom or policy of retirees being subject to future negotiations, but those individuals have the right to insist—before retirement, through their union representatives—on the right to full vesting of benefits. Once *Yard-Man* is applied, however, courts simply assume—or infer, or presume—that an employer

intended vesting based on factors such as tying the benefits to retirement status.

No one can disagree with Judge Sutton that the "precise weight of the *Yard-Man* 'inference' * * * is elusive." *Reese*, 574 F.3d at 321. The inference obviously does not mean that the employees win every time. What it does mean, though, is that employees win when there is no explicit *denial* of vesting and the health-care benefits are linked to retiree benefits (which is, of course, always the case). See, e.g., *Yolton* v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 583 (6th Cir. 2006); *Golden* v. *Kelsey-Hayes Co.*, 73 F.3d 648, 656-57 (6th Cir. 1996). *Yard-Man* is thus a proxy for arguing that contractual silence shows an intent to vest if the health-care benefits were granted in the retiree context.

The "trial" repeatedly invoked by respondents thus had nothing to do with the vesting question that has divided the circuits. That question was decided by the Sixth Circuit based solely on its interpretation of the collective bargaining agreement at issue. The bench trial simply determined "*what* vested" not whether anything vested as an initial matter. Pet. App. 64 (emphasis in original). The district court was only "called upon to explain whether what vested include[d] specific benefits." *Ibid.* Accordingly, the issue presented here involves no factbound inquiry warranting any deference to the trial court's findings. It is a textbook example of a circuit split that has led to wildly divergent outcomes and created incentives for inappropriate forum shopping.

The time has come to resolve this important and recurring question. Though this Court has denied certiorari in other cases raising this question, the petition here presents the issue cleanly and in a procedurally final posture. It is therefore an ideal vehicle for resolving the circuit split and bringing uniformity to retiree health-care benefit interpretation across the circuits.

III. Respondents Do Not Dispute The Existence Of A Related But Distinct Circuit Split

Respondents do not dispute the existence of a circuit split on the second question presented by the petition—whether the same rules of interpretation should apply to collective bargaining agreements as they do in the ERISA context. Instead, respondents offer only the conclusory assertion that both "ERISA plans and contractually bargained plans are interpreted in accordance with traditional rules of contract interpretation." Opp. 21; see also *id.* at 15 ("[E]very circuit resolves LMRA/ERISA retirement healthcare cases by applying traditional contract interpretation rules."). Respondents make no attempt to distinguish the cases cited in the petition that catalog the differences in approaches within the circuits. See Pet. 17-19.

The bulk of respondents' argument on this issue is devoted to refuting Judge Posner's view that the Sixth Circuit's presumptions—applying a "clear

statement rule" in the ERISA context, and an "inference" in favor of vesting in the collective bargaining context—should be reversed, if anything. *Rossetto*, 217 F.3d at 543-44. But that is an argument on the merits, not against review. Respondents' resort to merits arguments at this stage is both premature and revealing. And this is, once again, a dispositive issue—if the Sixth Circuit interpreted collective bargaining agreements the same way it approaches ERISA plans, the silence concerning vesting would have been resolved in favor of M&G. This case is thus an ideal vehicle for resolving that important, recurring issue, too—and respondents make no argument to the contrary.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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JOINT APPENDIX

Supreme Court, U.S.
FILED
JUL 17 2014
OFFICE OF THE CLERK

RECORD AND BRIEFS

No. 13-1010

In The
Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

JOINT APPENDIX

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Petition For Certiorari Filed February 20, 2014
Certiorari Granted May 5, 2014

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TABLE OF CONTENTS

Page

Relevant Docket Entries for the United States District Court for the Southern District of Ohio (Columbus), No. 2:07-cv-00126-GLF-NMK..... 1

Relevant Docket Entries for the United States Court of Appeals for the Sixth Circuit:

No. 07-4515 4
No. 07-4516 5
No. 12-3329 6
No. 12-3407 7

Pension, Insurance and Service Award Agreement between The Goodyear Tire & Rubber Company and United Rubber, Cork, Linoleum and Plastic Workers of America, et al., May 15, 1991 8

Agreement between The Goodyear Tire and Rubber Company, Point Pleasant Polyester Plant and Local No. 644 of the United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO, November 6, 1991..... 82

Pension, Insurance and Service Award Agreement between The Goodyear Tire & Rubber Company and United Rubber, Cork, Linoleum and Plastic Workers of America, et al., July 20, 1994 85

Supplemental Pension, Insurance and Service Award Agreement between The Goodyear Tire & Rubber Company and United Rubber, Cork, Linoleum and Plastic Workers of America, et al., July 20, 1994..... 86

TABLE OF CONTENTS – Continued

Page

Agreement between Shell Chemical Company, Point Pleasant Polyester Plant and Local No. 644 of the United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO, November 6, 1994 195

Pension, Insurance and Service Award Agreement between Shell Chemical Company, Point Pleasant Polyester Plant and Local Union 644 of the United Steelworkers of America, AFL-CIO-CLC, May 9, 1997..... 198

Agreement between Shell Chemical Company, Point Pleasant Polyester Plant and Local Union 644 of the United Steelworkers of America, AFL-CIO-CLC, November 6, 1997 275

Letter from David R. Jarrett and Duane Lee of Buck Consultants to Aly Kanji of Meynor Limited, December 16, 1999..... 278

Letter from David R. Jarrett and Duane Lee of Buck Consultants to Marco Ghisolfi of M.&G. Finanziaria Industriale S.p.A., December 17, 1999 289

M&G Completion of Acquisition of Shell Oil Company PET, Human Resources Agreement for U.S. and Mexican Employees, June 1, 2000 302

Company Response to Union's October 11, 2000 Inquiry re the P&I Agreement, October 17, 2000 331

TABLE OF CONTENTS – Continued

Page

Pension, Insurance and Service Award Agreement between M&G Polymers USA, LLC, Apple Grove Plant and Local Union 644L of the United Steelworkers of America, AFL-CIO-CLC, November 6, 2000 333

Letter H, January 1, 2001 435

Letter of Understanding 2003-6—Retiree Health Care Benefits, November 23, 2003 438

Email exchange among Marco Toselli, Kimm Korber, Pivetta Giorgia, and Robert Crooks, May 31, 2004 443

Agreement between M&G Polymers USA, LLC, Apple Grove Plant and United Steelworkers – USW, AFL-CIO-CLC, o/b/o United Steelworkers Local Union No. 644L, August 9, 2005 451

Email exchange among Duane Lee, Kimm Korber, and Robert Crooks, December 20, 2005 452

Excerpts from the Deposition of William Dale Wunder, August 9, 2010 456

Excerpts from the Deposition of David E. Dick, August 19, 2010 464

Excerpts from the Deposition of Duane P. Lee, September 14, 2010 471

Excerpts from the Deposition of James F. Kruse, September 15, 2010 486

TABLE OF CONTENTS – Continued

Page

Excerpts from Transcript of Bench Trial Proceedings, Volume I, May 9, 2011 495

Excerpts from Transcript of Bench Trial Proceedings, Volume V, May 13, 2011 499

The following opinions and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the appendix to the Petition for a Writ of Certiorari:

District Court Opinion and Order, November 21, 2007 .....Pet. App. 121

Circuit Court Opinion, April 3, 2009 .....Pet. App. 88

District Court Opinion and Order, February 21, 2012 .....Pet. App. 24

Circuit Court Opinion, August 12, 2013 .....Pet. App. 1

Circuit Court Denial of Petition for Rehearing, filed October 22, 2013 .....Pet. App. 148

Relevant Docket Entries for the United States District Court Southern District of Ohio (Columbus) CIVIL DOCKET FOR CASE #: 2:07-cv-00126-GLF-NMK

04/20/2007	14	AMENDED COMPLAINT against MGPolymers USA, LLC, MGPolymers USA, LLC Comprehensive Medical Benefits Program For Employees and Their Dependents filed by Plaintiffs Hobert Freel Tackett, Woodrow K. Pyles, United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union.(Simon, Stephen) (Entered: 04/20/2007)
		* * *
11/21/2007	63	ORDER granting 19 Defendant's Motion to Dismiss. Signed by Judge Gregory L Frost on 11/21/07. (sem1,) (Entered: 11/21/2007)
		* * *
04/29/2009	72	MANDATE of USCA as to 65 & 66 Notice of Appeal: The Sixth Circuit Affirm the District Court's dismissal of Plaintiffs' Section 502(a)(3) claim. It is Further Ordered that the case is REVERSED and REMANDED for further proceedings consistent with the opinion of this Court. (er1) (Entered: 04/29/2009)

* * *

06/04/2009 76 *Defendant's* ANSWER to 14 Amended Complaint, *and Affirmative Defenses* by Defendants MGPolymers USA, LLC, MGPolymers USA, LLC Comprehensive Medical Benefits Program For Employees and Their Dependents, MGCatastrophic Medical Plan, MGMedical Necessity Benefits Program of Hospital, Surgical, Medical, and Prescription Drug Benefits for Employees and Their Dependents, MGMajor Medical Benefits Plan. (Fusonie, Thomas) (Entered: 06/04/2009)

* * *

03/24/2011 163 ORDER denying 133 Defendants' Motion for Summary Judgment and granting 154 Plaintiffs' Motion for Reconsideration. Signed by Judge Gregory L Frost on 3/24/11. (sem1) (Entered: 03/24/2011)

* * *

08/05/2011 177 ORDER memorializing the May 2011 Bench Trial regarding liability. Signed by Judge Gregory L Frost on 8/5/11. (sem1) (Entered: 08/05/2011)

* * *

02/21/2012	209	ORDER granting 196 Plaintiffs' Motion for a Permanent Injunction. Signed by Judge Gregory L Frost on 2/21/12. (sem1) (Entered: 02/21/2012)

* * *

Relevant Docket Entries for the United States Court of Appeals for the Sixth Circuit (CIVIL DOCKET FOR CASE #: 07-4515)

04/03/2009	56	Per Curiam OPINION filed: AFFIRMED IN PART, REVERSED IN PART, case is REMANDED; decision for publication pursuant to local rule 206. Boyce F. Martin, Jr., Karen Nelson Moore, Circuit Judges; James S. Gwin, U.S. District Judge for the ND of OH. [07-4515, 07-4516] (LKM)

* * *

Relevant Docket Entries for the United States Court of Appeals for the Sixth Circuit (CIVIL DOCKET FOR CASE #: 07-4516)

04/03/2009	58	Per Curiam OPINION filed: AFFIRMED IN PART, REVERSED IN PART, case is REMANDED; decision for publication pursuant to local rule 206. Boyce F. Martin, Jr., Karen Nelson Moore, Circuit Judges; James S. Gwin, U.S. District Judge for the ND of OH. [07-4515, 07-4516] (LKM)

* * *

Relevant Docket Entries for the United States Court of Appeals for the Sixth Circuit (CIVIL DOCKET FOR CASE #: 12-3329)

08/12/2013	64	OPINION and JUDGMENT filed : The judgment of the district court is AFFIRMED. Decision for publication. Damon J. Keith, Boyce F. Martin, Jr., and R. Guy Cole, Jr. (AUTHORING), Circuit Judges. [12-3329, 12-3407] (CL)

* * *

Relevant Docket Entries for the United States Court of Appeals for the Sixth Circuit (CIVIL DOCKET FOR CASE #: 12-3407)

08/12/2013	49	OPINION and JUDGMENT filed : The judgment of the district court is AFFIRMED. Decision for publication. Damon J. Keith, Boyce F. Martin, Jr., and R. Guy Cole, Jr. (AUTHORING), Circuit Judges. [12-3329, 12-3407] (CL)

* * *

PENSION, INSURANCE AND SERVICE AWARD AGREEMENT

Effective May 15, 1991

Between

THE GOODYEAR TIRE & RUBBER COMPANY

and

UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC INTERNATIONAL UNION, AND LOCAL UNIONS:

NO. 2, AKRON & STOW, O; NO. 12, GADSDEN, ALA; NO. 200, ST. MARYS, O; NO. 286, LINCOLN, NEB; NO. 307, TOPEKA, KAN; NO. 831, DANVILLE, VA; NO. 835, MADISONVILLE, KY; NO 843, MARYSVILLE, O; NO. 878, UNION CITY, TENN; NO 904; SUN PRAIRIE, WISC.

* * *

FOREWORD

The following pages contain the Pension, Insurance and Service Award Agreement dated May 15, 1991, by and between The Goodyear Tire & Rubber Company and United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO-CLC International Union, and the Local Unions thereof listed therein, effective May 15, 1991.

Upon the adoption of the amendments to the 1950 Pension Plan of The Goodyear Tire & Rubber

Company provided for in the Pension, Insurance and Service Award Agreement dated May 15, 1991, the full text of the 1950 Pension Plan, as applicable to Employees covered by said Agreement who are also covered by the Plan and who retire on or after May 1, 1991, will be as set forth in the Exhibit A appearing at the end hereof.

PENSION, INSURANCE, AND SERVICE AWARD AGREEMENT

THIS AGREEMENT is made and entered into this 15th day of May, 1991, by and between THE GOODYEAR TIRE & RUBBER COMPANY, covering the plants operated by it as listed below, and UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC INTERNATIONAL UNION, and the local unions thereof listed below.

Wherever used in this Agreement,

(a) The term "Basic Agreement" means the present agreement dated May 15, 1991, between the parties hereto, or any new agreement, replacing such present agreement, hereafter entered into between the parties hereto; and the term "1988 Agreement" means the Pension, Insurance and Service Award Agreement entered into between the parties on April 23, 1988;

(b) The terms "Company" and "Employer" each mean The Goodyear Tire & Rubber Company;

(c) The term "Employee" means any employee of the Employer who, during the term of this Agreement, shall be in a bargaining unit covered by the Basic Agreement;

(d) The term "Union" means the United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO-CLC International Union; and

(e) The term "Local Union" means, as to each plant covered by this Agreement, the respective local union listed below which is the exclusive bargaining agency of the employees in certain bargaining units at such plant.

This Agreement is executed by representatives of the Union and by members of the International Policy Committee who represent the Local Unions involved.

The plants covered by this Agreement and their respective Local Unions are as follows:

Plant	**Local Union**
Akron and Stow Plants	2
Gadsden Plant	12
St. Mary's Plant	200
Lincoln Plant	286
Topeka Plant	307
Danville Plant	831
Madisonville Plant	835
Marysville Plant	843
Union City Plant	878
Sun Prairie Plant	904

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PART V
INSURANCE

Section A—Basic Life Insurance, Accidental Death and Dismemberment Insurance, Optional Contributory Life Insurance, and Survivor Income Benefits

Effective May 15, 1991, and for the duration of this Agreement thereafter, the Employer will provide the following standard form basic life insurance, accidental death and dismemberment insurance, optional contributory life insurance, and survivor income benefits for regular full time Employees beginning on the 31st day of employment:

1. Basic Life Insurance and Accidental Death and Dismemberment Insurance.

(a) The amount of basic life insurance benefit for each Employee shall be $23,000 and the amount of accidental death and dismemberment insurance shall be $23,000.

The amount of insurance payable in the event of the death of the Employee will be payable to the named beneficiary in accordance with the terms described in this Program.

(b) The full amount of basic life insurance benefits will be payable to the beneficiary in the event of the death of the Employee from any cause, at any place and at any time while insured under the Program.

(c) The full amount of the accidental death and dismemberment insurance benefit shall be payable if an accident causes the loss of:

Life
Both hands
Both feet
One hand and one foot
One hand and sight of one eye
One foot and sight of one eye
Sight of both eyes

One-half of such amount shall be payable if an accident causes the loss of one hand, one foot, or the sight of one eye; provided, however, that the full amount will be paid only once to or on account of any Employee.

The amount of insurance, subject to due proof of claim loss, will be payable to the Employee if living, otherwise to the beneficiary in accordance with the terms described in this Program.

Accidental death and dismemberment insurance benefits will be payable upon due proof that such loss resulted, directly and independently of all other causes, from bodily injuries caused by an accident occurring while the Employee was covered by this Program.

With respect to a hand or a foot, "Loss" means dismemberment by severance through or above the wrist or ankle joint. With respect to an eye, "Loss" means the entire and irrecoverable loss of the sight of such eye. With respect to losses involving partial loss

of a bodily member or the partial loss of the sight of an eye, "Loss" shall also mean the loss of all functional use of the hand, foot or eye.

Accidental death and dismemberment insurance does not cover any loss caused directly or indirectly, wholly or partly, or contributed to substantially, by bodily or mental infirmity, or ptomaines, or bacterial infections (except pyogenic infections which occur through an accidental cut or wound); or any other kind of disease; or medical or surgical treatment (except such as may result directly from surgical operations made necessary solely by injuries); or war, or any act of war; or suicide, sane or insane.

(d) BENEFICIARY.

(i) The Employee may designate a beneficiary or beneficiaries or change the designation of such beneficiary or beneficiaries from time to time by written notice on form provided by the Employer. Such designation or change will take effect as of the date of execution of such request but without prejudice to the Employer on account of any payments made prior to receipt of such request.

If any designated beneficiary predeceases the Employee, the share which such beneficiary would have received if surviving the Employee will be payable equally to the remaining designated beneficiary

or beneficiaries, if any, who survive the Employee.

If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made to the Employee's spouse, if surviving the Employee; if not surviving the Employee, in equal shares to the Employee's children who survive the Employee; if none survives the Employee, to the Employee's parents, equally, or to the survivor; if neither survives the Employee, in equal shares to the Employee's brothers and sisters who survive the Employee; or, if none survives the Employee, to the Employee's executors or administrators.

In any case, the Insurance Company may, on instructions from the Employer, deduct from the benefits payable an amount not to exceed $1,000 to cover expenses incurred for the Employee's burial.

(ii) Payment of death benefits will be made in one sum upon proof of claim. The beneficiary may, after death of the Employee but before payment is made, elect that the whole or any part of the benefit be payable in accordance with method (1) or (2) below or in accordance with such other method of settlement as shall be elected by the beneficiary and agreed to by the Insurance Company.

(1) Payment in equal monthly installments extending over a fixed period

of years. The fixed period of years must be specified in the election and may not exceed twenty, and in no event will the Insurance Company be required to pay an installment of less than $10.00 to any one person.

(2) Payment in monthly installments of any fixed amount specified in the election (which may not be less than $5.00 per month per $1,000 so payable nor less than $10.00 per month regardless of the amount so payable), until the amount so payable with interest is exhausted. With respect to each such election, the rate of interest to be allowed on the unpaid balance shall be determined by the Insurance Company but shall in no case be less than 3% per annum.

At the death of a beneficiary to whom a death benefit claim is being paid under method (1) or (2) above, the present value of any unpaid installments under method (1) above, commuted on the basis of 3% interest per annum, or any unpaid balance under method (2) above, as the case may be, will be paid in one sum to the executors or administrators of the beneficiary.

(e) The insurance coverage described in Paragraph 1(a) of this Section A shall be likewise provided for any Employee absent on the Effective Date, under a leave of absence

granted by his Employer, and the insurance coverages provided to any Employee in accordance herewith shall be continued in force during the period of any absence for which he is granted a leave of absence by his Employer, except in cases where such Employee is employed by a Local Union in other than an official or representative capacity, or is employed in any capacity by the International Union.

(f) If an Employee for whom insurance coverages are provided in accordance herewith shall be retired on a disability pension under the 1950 Pension Plan, the full amount of his basic life insurance (but not his accidental death and dismemberment insurance) shall be continued in force for the period of such disability (subject to the furnishing of due proof of its continuance) or until he attains age 65, whichever first occurs. In the event such disability continues after attainment of age 65, the amount of basic life insurance shall be reduced on the first day of the month following the month in which he attains age 65 and on the first day of each succeeding month thereafter by an amount equal to 1/30th of the difference between $2,250 and the amount of basic insurance in effect at the time of his retirement; provided, however, that such monthly reductions shall not operate to reduce the amount of basic insurance below a minimum amount of $2,250, which minimum amount shall then be continued in force during such Employee's remaining lifetime.

(g) Except as provided herein, all insurance coverages provided hereunder for any Employee, other than a laid-off Employee, shall cease on the date 31 days following any termination of such Employee's active employment; all insurance for a laid-off Employee shall cease on the date 90 days following termination of active employment; provided, however, that the basic life insurance (but not the accidental death and dismemberment insurance) benefit shall be continued in force for all Employees who retire and receive a monthly pension under the normal or early retirement provisions of the 1950 Pension Plan, and for all Employees who receive Service Awards (as distinguished from Special Distributions and Separation Payments) under the 1950 Pension Plan subject to reduction on the first day of the month following the month in which he receives a Service Award, or in the case of normal or early retirement, retires or attains age 62, whichever later occurs, and on the first day of each succeeding month thereafter in an amount equal to 1/30th of the difference between $2,250 and the amount of basic insurance in effect at the time of his retirement until the amount of basic insurance is reduced to a minimum coverage of $2,250; provided, however, that for Employees who continue in employment after attaining age 65 and retire with a normal retirement pension, his amount of basic life insurance on the first day of the month following the month of retirement shall be determined as if he had retired upon

attainment of age 65 with the applicable reductions from age 65; and provided further that in the case of any other Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated at or after his attainment of age 60, basic life insurance (but not accidental death and dismemberment insurance) coverage in the amount of $2,250 shall be made effective with respect to such Employee as of the first day of the month for which he receives a deferred vested pension, and shall thereafter be continued during his lifetime. If an Employee returns to active employment within such time and under such circumstances that he is credited with previous service in accordance with the Basic Agreement, insurance shall be immediately provided for him in the amounts set forth in Paragraph 1(a) of this Section A.

A laid-off Employee may, within 90 days following layoff, arrange to continue the full amount of his basic life insurance coverage and accidental death and dismemberment insurance by payment in advance at the rate of $0.55 per $1,000 of insurance per month for the period equal to the maximum number of full weekly SUB benefits to which Employee's credit units as of last day worked prior to lay-off would entitle him under the Supplemental Unemployment Benefits Plan but not less than 24 months following the date of layoff, provided, however, that upon acceptance of a Separation Payment under Article XIII of the 1950 Pension Plan, the

Employee shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this sub-paragraph (g).

(h) Conversion Privilege. In case of termination of insurance coverage for any reason whatsoever, the Employee will be entitled to have a policy of life insurance issued by the Insurance Company without further evidence of insurability, provided:

(i) the amount of the policy may not exceed the amount of the Employee's life insurance under the Program at the time the coverage terminated,

(ii) the policy must be upon one of the non-participating forms then customarily being issued by the Insurance Company, except Term Insurance,

(iii) the policy will require payment of the premium applicable to the class of risk to which the Employee then belongs and to the form and amount of the policy at the Employee's then attained age,

(iv) written application for such a policy and payment of the first premium must be made by the Employee within thirty-one days after termination of such coverage and such policy will become effective at the end of such thirty-one days.

The Employee whose insurance is reduced because of (1) being retired on pension,

(2) being granted a service award, or (3) attaining age sixty-five while retired on a disability pension under the 1950 Pension Plan will, to the extent set forth below, be entitled to the rights granted under this section:

(i) If the Employee's insurance is, in accordance with the terms of the Program subject to only one such reduction, the Employee will be entitled to said rights, as to the amount of the reduction, as though coverage had terminated on the date of the reduction in insurance.

(ii) If the Employee's basic insurance is, in accordance with the terms of the Program subject to more than one such reduction, the Employee will, on the day of the first such reduction and on the first day of the sixth, twelfth, eighteenth, and twenty-fourth calendar months following the day of the first reduction, be entitled to said rights, in an amount equal to one-fifth of the difference between $2,250 and the amount of insurance in effect at the time of his retirement, as though the Employee's coverage had terminated on that day.

(iii) If the Employee's Optional Contributory Life Insurance is, in accordance with the terms of the Program, subject to more than one such reduction, the Employee will, on the day of the first such reduction and on the first day of the fourth, seventh, and tenth calendar

months following the day of the first reduction, be entitled to said rights, in an amount equal to 25% of the amount of insurance in effect at the time of his retirement, as though the Employee's coverage had terminated on that day.

If the Employee fails to exercise any conversion right from a reduction in the amount of his insurance, the Employee will not, thereafter, be entitled to convert the amount of any subsequent reduction in the amount of his insurance.

If the Employee dies during the thirty-one day period within which he is entitled to have an individual policy issued to him under the conversion privilege and before any such individual policy has become effective, the amount of life insurance which the Employee is entitled to have issued to him under such individual policy will be payable as a claim under the Program, whether or not application for the individual policy or the payment of the first premium therefore has been made.

(i) It is the intent of this Paragraph 1 that Employees shall be provided, beginning May 15, 1991, without cost to them, with the basic life insurance and accidental death and dismemberment insurance benefits previously provided under existing group insurance plans underwritten by Aetna Life Insurance Company, including the benefit increases provided in Paragraph 1(a) of this Section A.

(j) Assignment—Claims of creditors. Neither the Employee nor the beneficiary may assign the insurance or other benefits under this Program.

Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under the program shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Employee or his beneficiaries.

2. Optional Contributory Life Insurance.

(a) Employees who are covered for Basic Life Insurance benefits will also be eligible to enroll for and be covered by Optional Contributory Life Insurance.

(b) Eligible Employees must enroll and authorize deductions of contributions for Optional Contributory Life Insurance based upon the following schedule:

CONTRIBUTION PER $1,000 OF INSURANCE

Age	Per Month
Under 30	$.30
30-34	.35
35-39	.40
40-44	.45
45-49	.50
50-54	.55
55-59	.60
60-64	.65

65-69	.70
70 and over	.80

(Monthly contributions will be based on Employee's current age)

(i) The initial enrollment period will be the thirty-one (31) days following the Effective Date and the coverage will become effective upon enrollment.

(ii) For Employees hired after the Effective Date, coverage will become effective on the day the Life Insurance, pursuant to Paragraph 1 of this Section A, becomes effective, provided the Employee enrolled on or prior to that date.

(c) A medical examination at the Employee's expense may be required to provide evidence of insurability satisfactory to the carrier:

(i) if the Employee does not enroll during the enrollment periods described in (i) of sub-paragraph (b) above;

(ii) if an Employee hired after the Effective Date does not enroll within thirty-one (31) days after becoming eligible;

(iii) if an Employee who elected an amount equal to 50%, 100% or 200% of Basic Life Insurance elects an increased amount.

(iv) or if the Optional Contributory Life Insurance previously terminated because an Employee revoked the required payroll deduction authorization.

(d) Employees enrolled for Optional Contributory Life Insurance may elect to be insured for an amount equal to 300%, 200%, 100% or 50% of their Basic Life Insurance.

Employees enrolled for Optional Contributory Life Insurance will be provided with Dependent Life Insurance as follows:

For Employees electing 300% of coverage:

Spouse $10,000 Child $5,000

For Employees electing 200% of coverage:

Spouse $10,000 Child $4,000

For Employees electing 100% of coverage:

Spouse $ 7,500 Child $3,000

For Employees electing 50% of coverage:

Spouse $ 5,000 Child $2,000

(i) A "dependent" means the Employee's spouse, if married at least a year prior to death or the Employee's unmarried child at least six months of age but under nineteen years of age, however, any person who is in full-time military service shall not be considered a dependent.

(ii) A "child" means the Employee's own natural or legally adopted child or step child who lives with the Employee and depends upon him for support and maintenance.

The word "child" means in addition to the Employee's own children as defined above, such foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, or marriage, such dependent shall not become eligible until three months have elapsed from the date such child was added to the Employee's medical enrollment.

(iii) The amount of insurance payable under the Dependent Life Insurance provision shall be payable to the Employee in the event of death of the Dependents from any cause.

(e) Optional Contributory Life Insurance is payable in event of death from any cause while an Employee is insured. The insurance will be paid to the beneficiary designated by the Employee under the Basic Life Insurance and Accidental Death and Dismemberment Insurance plan.

(f) The Optional Contributory Life Insurance coverage shall cease on termination of an Employee's active employment, including any layoff or retirement.

However, Employees who retire and receive a monthly pension with a normal, disability or early retirement pension under the 1950

Pension Plan and who have made all contributions required in the 24-month period immediately preceding the date of retirement will have the Employee's and his dependent's insurance continued without payment of monthly contributions in accordance with the following schedule:

PERIOD AFTER RETIREMENT FOR WHICH EMPLOYEE'S INSURANCE WILL BE CONTINUED WITHOUT CONTRIBUTIONS	PER CENT OF OPTIONAL CONTRIBUTORY LIFE INSURANCE IN EFFECT AT RETIREMENT TO BE CONTINUED
1st through 3rd month	100 %
4th through 6th month	75 %
7th through 9th month	50 %
10th through 12th month	25 %

Moreover, commencing with the 13th month after retirement the Employee's insurance, but not the Dependent's insurance, will be continued during the Employee's remaining lifetime, provided such Employee also has made all contributions required for the 120 months immediately prior to the date of retirement, in accordance with the following schedule:

Amount of Coverage Elected	**Amount of Insurance Continue**
300 %	$3,200
200 %	$2,420
100 %	$1,700
50 %	$1,200

In no event, however, will the amount to be continued be based on any increase in the amount of insurance which the employee voluntarily elected within the 24-month period immediately preceding date of retirement.

Employees who are covered for Basic Life Insurance, pursuant to Paragraph 1 of this Section A, during layoff, leave of absence, or sick leave, may while so covered, also continue the Optional Contributory Life Insurance coverage by making arrangements for the required monthly contributions to be paid directly to the Employer Optional Contributory Life Insurance coverage will also terminate if the Employee fails to make the required contributions within thirty-one (31) days following written notice of contributions due, mailed to the last address on file with the Employer Optional Contributory Life Insurance is subject to the conversion privilege upon termination of such insurance.

3. Survivor Income Benefits

(a) If an Employee dies on or after the Effective Date while covered for Survivor Income Benefits, leaving one or more Survivors, as defined below, payment of not more than 24 monthly Survivor Income Benefits ("Transition Survivor Income Benefits") shall begin, provided at least one of such Survivors is living on the first day of the month following the Employee's death and then qualifies as his survivor. An Employee shall be covered for monthly Transition Survivor Benefits while

he is on the payroll of the Employer, on sick leave (and accumulating seniority), on layoff or on authorized leave of absence for a period not to exceed 90 days, or on authorized leave of absence for service with a Local Union in an official representative capacity. An Employee on leave of absence extending beyond such 90 day period, other than on sick leave (and accumulating seniority) or authorized leave of absence for service with a Local Union in an official representative capacity, may arrange to continue his Survivor Income Benefit coverage by payment in advance of the current monthly group rate premium during the period of such leave of absence.

(b) The amount of the monthly Transition Survivor Income Benefit shall be $450 for any month in which there is only one Survivor of the deceased Employee eligible to receive such Benefit. The Transition Survivor Income Benefit payable hereunder shall be reduced by the amount of any Pre-Retirement Benefit payable under the Special 50% Joint and Survivor Option of the 1950 Pension Plan provided, however, such reduction will not reduce the Transition Survivor Income Benefit below $300. For any month in which there are two or more Survivors of the deceased Employee eligible for a Transition Survivor Income Benefit, the amount of Benefit payable hereunder to each such Survivor for such month shall be a fraction of the Benefit that would be paid to him as a sole Survivor, the numerator of such fraction being 1 and the denominator of such fraction being a number

equal to the total number of all Survivors who would be eligible for a Transition Survivor Income Benefit but for their eligibility for Federal Social Security Benefits. No monthly Transition Survivor Income Benefit, however, shall be paid for any month to any Survivor who has attained age 62 or is eligible for an old-age, disability, widows or widowers unreduced benefit under the Federal Social Security Act as then in effect.

(c) The first such Benefit is payable on the first day of the month following the Employee's death. Thereafter, a monthly Transition Survivor Income Benefit is payable on the first day in each of the next 23 months, but if on the first day of any month after the Employee's death no person then living qualifies as his Survivor, no such Benefit is payable for that month or any subsequent month.

(d) Survivors are classified and defined as follows:

(1) A "Class A Survivor" means the Employee's spouse, whether or not remarried, but only if married to the Employee for at least a year immediately prior to the Employee's death, and only if spouse was wholly or partially dependent on the Employee at the time of the Employee's death.

(2) A "Class B Survivor" means the Employee's child who at the Employee's death and at the time a Survivor Income Benefit first becomes payable to such child is

both unmarried and either (i) under 21 years of age, or (ii) at least age 21 but under age 25, or (iii) totally and permanently disabled at any age over 21; provided, however, that a child under clause (ii) or (iii) must have been legally residing with and dependent upon the Employee at the time of his death. A child ceases to be a Class B Survivor upon marrying or if not totally and permanently disabled, upon reaching his or her 25th birthday. To qualify as the Employee's child, the child must be one of the following:

(i) the Employee's own child born prior to the first of the month following the Employee's death,

(ii) the Employee's legally adopted child or a child with respect to whom he had initiated legal adoption proceedings which were terminated by his death,

(iii) the Employee's step-child who resided with him at the time of his death.

(3) A "Class C Survivor" means the Employee's parent for whom he had during the calendar year immediately preceding his death, provided at least 50% of such parent's support, if such parent was

(i) the Employee's father or mother by blood relationship, or

(ii) the Employee's adopting parent.

(4) The Survivors entitled to each monthly Transition Survivor Income Benefit that becomes payable under this Paragraph 3, Survivor Income Benefits, shall be determined as follows:

(i) the Employee's Class A Survivor who is living on the first day of a month shall be entitled to the Benefit payable for such month;

(ii) if the Employee's Class A Survivor is not living on the first day of a month, persons who qualify on that day as his Class B Survivors excluding any then deceased, shall be entitled to the Benefit payable for that month;

(iii) if the Employee's Class A Survivor is not living on the first day of a month and no living person qualifies on that day as the Employee's Class B Survivor, persons who qualify on that day as the Employee's Class C Survivors, excluding any then deceased, shall be entitled to the Benefit payable for that month.

(e) A laid-off Employee may within 90 days following layoff, arrange to continue the amount of his Survivor Income Benefit coverage by payment in advance of the current monthly group rate premium but not for

longer than 24 months following the date of layoff.

(f) An Employee may not assign his Survivor Income Benefits and his Survivors may not assign any monthly Survivor Income Benefit that becomes payable. To the extent permitted by applicable law, monthly Survivor Income Benefits shall not be subject to attachment or other encumbrance or subject to the debts or liability of any Survivor.

(g) Survivor Income Benefits become payable only if due proof of the Employee's death is submitted to the Employer. Payment of each monthly Survivor Income Benefit is subject to the condition that the person claiming the Benefit submit to the Employer due proof of entitlement to such benefit.

(h) If the Employee dies after attaining age 45 while covered for Transition Survivor Income Benefits and if such Employee is survived by a Class A Survivor, such Survivor shall become eligible for Bridge Survivor Income Benefit. The monthly amount of the Bridge Survivor Income Benefit shall be $450. The Bridge Survivor Income Benefit payable hereunder shall be reduced by the amount of any Pre-Retirement Benefit under the Special 50% Joint and Survivor Option of the 1950 Pension Plan provided, however, such reduction will not reduce the Bridge Survivor Income Benefit below $300.

A Bridge Survivor Income Benefit shall be paid to an eligible Survivor on the first day of

each month, beginning with the 25th calendar month following the death of the Employee and ending with the first day of the month in which such Survivor remarries, dies, attains age 62 or attains such lower age at which full widows or widowers Insurance Benefits become payable under the Federal Social Security Act as it may be amended; provided, however, that no monthly Bridge Survivor Income Benefit shall be payable for any month for which such Survivor receives a Mother's Insurance Benefits under such Act.

SECTION B—Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions or Comprehensive Medical Benefits Program and Employee Savings Plan for Employees and Their Dependents

Effective January 1, 1992 and for the duration of this Agreement thereafter, the Employer will provide a Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions as described in Exhibit B attached hereto and made a part hereof by reference or a Comprehensive Medical Benefits Program and Employee Savings Plan as described in Exhibit C attached hereto and made a part hereof by reference.

Each active Employee shall be afforded a choice prior to the Effective Date, to elect one of the programs of either (a) or (b) as follows:

(a) Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions or

(b) Comprehensive Medical Benefits Program and Employee Savings Plan.

An Employee not actively at work on the Effective Date shall make his election of benefits coverage immediately on his return to work.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

An Employee hired after the Effective Date shall make his election of benefits coverage prior to his 31st day of employment.

If on the Effective Date or on the 31st day of employment for an Employee who was hired after the Effective Date, the Employer has not received an election of benefits coverage from an Employee, such Employee will be deemed to have elected the Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions. An election of benefits coverage by an Employee or benefits coverage determined by failure of an Employee to make an election, shall remain in effect for the duration of this Agreement.

An Employee who retires and receives a monthly pension (other than a deferred vested pension) and is eligible for benefits under either Exhibit B or Exhibit C shall have his medical benefits after retirement provided under the program that applied to him immediately prior to his retirement; provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Effective January 1, 1989, and consistent with the provisions of COBRA and any subsequent amendments thereto, the Company will make available the options for continuation of health care coverage prescribed by COBRA, to employees, spouses, former employees, former spouses and former eligible dependents. The medical benefit continuation options prescribed by COBRA shall be concurrent with any continuation of benefits otherwise provided in this Section B and Exhibits B-1, B-2, and C-1.

* * *

SECTION F—General Provisions For Part V, Sections A, C, D and E

1. Medical Examination by Employer

(a) Disabilities giving rise to claims for any benefits under Section C of this Part V may be verified by the Employer by medical examination at any reasonable time. Benefits may be suspended if the claimant fails to have such examination made.

(b) If any dispute shall arise concerning the disability of any Employee, such difference shall be resolved as follows: The Employee shall be examined by a physician appointed for the purpose by the Employer. If the Employer's physician and the Employee's physician should disagree concerning the disability, that question shall be submitted to a third physician selected by such two physicians. The medical opinion of the third physician after examination of the Employee and consultation with the other two physicians shall decide such question. A copy of the third physician's report will be provided to both the Employer's and the Employee's physician. The expenses of the third physician shall be borne jointly by the Employer and the Employee.

2. Listing of Dependents

Each Employee shall furnish a list of his eligible dependents on an enrollment card supplied by the Employer for such purpose. This card must be kept up to date at all times.

3. Definition of "Physician", etc.

The term "physician", or "doctor" or "doctor licensed to practice medicine", or "doctor licensed to practice dental surgery" as used in this Part V means only a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) or a Doctor of Dental Surgery (D.D.S.), except that with respect to surgical operations coming within the scope of the "Schedule of Surgical Operations—Chiropody" the term also means a Doctor of Surgical Chiropody (D.S.C.) (Podiatrist) and with respect to chiropractic treatments for neuromusculoskeletal conditions coming within the scope of his license, the term shall also mean a Chiropractor.

For the purposes of Section C the term "doctor licensed to practice medicine" means also a Doctor of Surgical Chiropody (D.S.C.) (Podiatrist) when the doctor is acting within the scope of his license. Further, for purposes of Section C the term "doctor licensed to practice medicine" means a Chiropractor acting within the scope of his license.

4. Insurance Contracts

The Employer may, alone, or in conjunction with other corporations subsidiary to or affiliated with the Company, enter into a contract or contracts with an insurance company or insurance companies to provide the benefits described in this Part V. No insurance company contract which may be entered into by the Employer for the purpose of providing any benefits described in this Part V shall alter, amend or detract from the provisions of this Agreement.

5. Grievance Procedure

If any difference shall arise between the Employer and any Employee with respect to whether or not the Employer has provided the benefits under this Part V, and if agreement cannot be reached between the Employer and such Employee, such difference may be taken up as a grievance under the grievance procedure provided for under the Basic Agreement at the Manager of the Labor Department level. If any such grievance shall be taken before the impartial umpire in accordance with such procedure, then the impartial umpire shall have the authority only to decide the question pursuant to the provisions of this Part V applicable to the question, but he shall have no authority in any way to alter, add to, or subtract from any such provisions. The decision of the impartial umpire shall be binding on the Employer, such Employee, and all other interested parties. Termination of the Basic Agreement shall not invalidate the use of its grievance procedure for the purposes of this Part V.

6. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 6 is provided in lieu of all other coverage under Part V, Section A of the Agreement and Exhibit B or Exhibit C-1. However, upon termination of coverage under this Paragraph 6, the conversion privileges of Part V, Section A, Paragraph 1 of the Agreement and Exhibit

B or Exhibit C-1 as well as the termination provisions of Exhibit B or Exhibit C-1 shall apply.

Coverage under Part V, Section A of the Agreement will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of Section A. Coverage under Exhibit B or Exhibit C-1 will be extended following such Plant Closure without cost to the Employee for an additional 12 months beyond Employer-furnished coverages provided in Exhibit B or Exhibit C-1. However, in no event shall the coverage provided in Exhibit B or Exhibit C-1 be less than 9 months. For any month in which Employer-furnished coverage is provided under Paragraph 1, Part V Section A of the Agreement, the Employee may continue to purchase coverage under Paragraph 2 of Section A.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Goodyear Supplemental Unemployment Benefits Plan, coverage under Exhibit B or Exhibit C-1 may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 6 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 and 36 consecutive months for coverage under Exhibit B or Exhibit C-1 following the month in which such Plant Closure occurred.

Coverage under this Paragraph 6 will not continue as provided above while the Employee is covered by any other Employer sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 6.

PART VI
DURATION AND TERMINATION

1. Subject to the conditions set forth in Part II hereof, this Agreement shall become effective as otherwise set forth in this Agreement, upon approval by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union, and shall then supersede the 1988 Agreement. Should this Agreement not have been approved by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union prior to June 5, 1991, all references in this Agreement (and the Exhibits hereto) to May 15, 1991, shall be construed to refer to the date as of which such approval is given.

2. This Agreement constitutes a settlement for the duration of this Agreement of all issues with respect to the subject matters covered hereby,

and, while this Agreement continues in effect, the Employer shall have no obligation to negotiate or bargain with the International Union or any Local Union (except as noted in connection with grievance procedures) with respect to any subject matter covered hereby, nor shall there be any strike or work stoppage with respect to such matters. Any termination of the Basic Agreement in accordance with the provisions thereof shall not affect the duration of this Agreement nor shall such termination of the Basic Agreement be deemed to open for negotiation the subject matters covered by this Agreement. The fact that this Agreement continues in effect shall not prevent the parties from engaging in a strike or lockout with respect to any subject matter not covered by this Agreement, if such strike or lockout may be engaged in lawfully under the terms and provisions of the Basic Agreement.

3. The International Union or the Employer may request renegotiation of the provisions of this Agreement and termination of the Basic Agreement and local supplements thereto by giving a written notice to the other party not more than 75 days nor less than 60 days prior to April 23, 1994, or any April 23 thereafter. In such event, if negotiations are not completed prior to the April 24 next following the giving of such written notice, this Agreement, together with the Basic Agreement and local supplements thereto shall terminate unless otherwise agreed upon.

4. In the event at any time the Basic Agreement and the local supplements thereto shall have been terminated as a result of the termination of

this Agreement as provided in the preceding Paragraph 3 and the parties shall subsequently settle the issues involved in this Agreement which resulted in the termination thereof, the Basic Agreement and the local supplements thereto shall be immediately reinstated in full force and effect.

5. In the event that right, title or possession to any or all of the plants covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale, or any other method of disposition or acquisition, the benefits provided in this Agreement shall be binding upon the Company and its successors and assigns.

IN WITNESS WHEREOF THE PARTIES HERETO HAVE HEREUNTO SET THEIR HANDS THIS 15TH DAY OF MAY, 1991.

THE UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC

INTERNATIONAL UNION
Kenneth Coss
Thurston Smith
Ron Hoover

LOCAL UNION NO. 2, URCLPWA
Dan Kelly
William Demboski

LOCAL UNION NO. 12, URCLPWA
J. R. Countryman
O. A. Garrard
R. L. Hayes

THE GOODYEAR TIRE & RUBBER COMPANY

F. R. Tully
G. K. Lummis
M. L. Clevenger, Jr.
D. F. Neff
J. F. Kruse
E. D. Wade
P. W. Dukeshire, Jr.
T. L. Lammlein
D. H. Smith
J. R. Stebbins, II
M. J. McColgan
F. Lai
J. L. Allen

LOCAL UNION NO. 200,
URCLPWA
Lawrence Larkin

LOCAL UNION NO. 286,
URCLPWA
Jared Teichmeier
George Oberembt

LOCAL UNION NO. 307,
URCLPWA
Tony Stattelman
W. J. Leiker

LOCAL UNION NO. 831,
URCLPWA
Linwood Saunders
Benny Toller

LOCAL UNION NO. 835,
URCLPWA
John M. Dugger

LOCAL UNION NO. 843,
URCLPWA
John I. Rutherford

LOCAL UNION NO. 878,
URCLPWA
Paul E. Sanford
Sam Odom, Jr.
Ronnie Dotson

LOCAL UNION NO. 904,
URCLPWA
Jim Dushack

D. T. Shaffer
P. F. Ess
S. G. Neely
W. B. Miller
R. W. Lindsay, Jr.
C. H. Lyndon
J. A. Czervionke
C. J. Allmand

* * *

EXHIBIT B

MEDICAL NECESSITY BENEFITS PROGRAM

AND

MAJOR MEDICAL BENEFITS PROGRAM

EXHIBIT B-1

MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January 1, 1992, and for the duration of this Agreement thereafter, the Employer will provide the following Program of hospital benefits, hospital-medical benefits, surgical benefits, and prescription drug benefits, subject to the Medical Necessity Review requirements of Paragraphs 1(c), with the exception that none of the aforesaid benefits shall be applicable in the event of accident or sickness covered by a Workers' Compensation Act nor shall there be any duplication of benefits under any Employer-sponsored Program.

1. Hospital Expense Benefits for Employees and Dependents

(a) General

Benefits will be paid for hospital confinement due to an accident or sickness which is approved by a doctor licensed to practice medicine. In no event, however, will benefits he paid for rehabilitation treatment of drug addicts or alcoholics in a hospital, in a wing

or section of a hospital or in a facility connected with a hospital.

For semi-private accommodations the benefit for a certified day will be equal to the hospital's daily charge for room and board for a semi-private room.

For private accommodations for a certified day, an allowance will be paid equal to the hospital's average daily charge for room and board for a semi-private room.

No benefits will be payable unless the hospital makes a charge for board and room except as provided in Paragraph (b) following.

(b) Benefits

The following benefits are provided:

(i) Room and board benefits will be paid for both certified and non-certified days up to a maximum of 730 days for any one confinement. There will be no limit to the number of hospital confinements for which benefits are paid if they are due to different causes, or if they are separated by completed recovery or a period of 90 days, or, in the case of an Employee, if they are separated by a return to full time work. This provision includes maternity benefits for female Employees and wives of Employees.

(ii) When there is a certified or non-certified hospital charge for room and board, additional benefits will be provided

without limit for the following: miscellaneous hospital-medical services and supplies, administration of anesthesia, ambulance service provided by any hospital or professional ambulance service and charges made by hospital-approved physicians or other medical technicians for services utilizing hospital equipment, when such services are not provided by the hospital or performed by members of the hospital's staff.

The term "miscellaneous hospital-medical services and supplies" shall include bandages, crutches, splints, braces and trusses (including services related to initial fitting and adjustment of these items) when provided and billed by the hospital or other professional qualified personnel.

The term "miscellaneous hospital-medical services and supplies" shall also include hospital charges for "supplementary medical service", "room and board supplement", "special room supplement", "isolation", "contagious", "intensive care", "cardiac care unit", or similar terms of like meaning if such services are, in fact, so billed and certified by the hospital to be hospital medical services and/or hospital medical supplies.

(iii) The benefits of sub-paragraph (ii) will also be paid when there is no hospital charge for room and board if the

Employee or his dependent receives electro-shock therapy in a hospital or is confined in a hospital either for an operation or for emergency care following an accident (including removal, wherever performed, of sutures, clamps, or casts applied for treatment of injuries sustained in such accident). Such outpatient electro-shock therapy or emergency care for which benefits are payable shall include charges by a doctor where not routinely provided by the hospital, provided such doctor personally treats the patient and is not an employee of the hospital.

(iv) When usual miscellaneous hospital-medical services are not available in a hospital or when for other legitimate reasons a doctor decides to provide such services in the hospital, the charges will be paid, provided such charges do not exceed the usual hospital charges for such services.

(c) Hospital Admission Certification Provisions

Whenever benefits are provided in accordance with subparagraphs (a) or (b) above, the amount of any such benefit payable will be subject to hospital admission certification approval by the Carrier. Certification approval by the Carrier will be required as follows:

(i) Non-emergency medical or surgical admission will require Pre-Admission Certification as to the need for confinement.

(ii) Emergency admission will require notification to the Carrier within 48 hours after the admission (or if longer, on the first business day following a weekend or holiday admission) and certification, approval as to length of stay. When an emergency admission confinement does not exceed 48 hours, certification approval by the Carrier will not be required.

(iii) Certification approval of hospital confinement admission will require concurrent review certification as to the continued need for confinement and length of stay.

(iv) Pre-Admission Testing (PAT) under an approved PAT program at the hospital in which surgery is to be performed will be required on all non-emergency surgery.

When certification is required and the Carrier does not grant such certification approval, the benefits otherwise payable in subparagraphs (a) and (b) above, will be provided as follows:

(i) 75% of the hospital's daily charges for the weekend days of Friday or Saturday when a non-emergency admission occurs on such days unless surgery was performed on such weekend days of Friday,

Saturday or Sunday or it was medically necessary for the patient to be admitted on the weekend days of Friday or Saturday.

(ii) 75% of the hospital's daily charges for the days of any admission where required certification was not obtained.

(iii) 75% of the hospital's daily charges for any days following the initial certification of a specified number of days for which certification approval was not obtained.

(iv) 75% of the hospital's daily charge for room and board for the first certified day of confinement when an approved Pre-Admission Testing (PAT) program was available at the hospital and such PAT was not used unless due to medical reasons.

The required certification approvals described in this subparagraph will be made by a Physician Advisor of the Carrier following a review and evaluation of medical information provided by the patient's attending physician or by the Carrier using established medical criteria to determine medical necessity and appropriateness of the admission and proposed plan of treatment. If the patient's attending physician and the Carrier's Physician Advisor are unable to reach agreement concerning the patient's need for hospital confinement or continued confinement, the need for such confinement will be decided by a "local panel" physician.

2. Outpatient Treatment and Diagnostic Services

(a) Benefits

(i) Charges directly connected with x-rays or fluoroscopy for diagnostic purposes will be paid wherever performed when authorized by a doctor licensed to practice medicine, a doctor of dental surgery, or a doctor of surgical chiropody.

Notwithstanding the above procedures done for diagnostic purposes in the event of accident or illness, charges will also be paid for:

(1) routine PAP test.

(2) routine mammogram when performed once every two years between the age of 50 and 59 and annually upon the attainment of age 60.

(ii) Charges made for diagnostic laboratory tests will be paid wherever performed when authorized by a doctor licensed to practice medicine.

(iii) Charges made for diagnostic Computerized Axial Tomographic (CAT) scans or Magnetic Resonance Imaging (MRI) scans will be paid wherever performed when authorized by a doctor licensed to practice medicine. The charges for the first CAT scan or MRI scan performed on a patient during any calendar year will

not be used in the computation of the maximum annual allowance described in subparagraph (b) below.

(iv) Charges made for such medical tests as basal metabolism, electrocardiographs and electroencephalograms will be paid wherever performed when authorized by a doctor licensed to practice medicine.

(v) Charges made by a hospital for necessary medical care performed in the hospital's outpatient department for treatment of a physical disorder not arising from an accident when authorized by a doctor licensed to practice medicine. Such medical care shall include all the hospital-medical services and supplies and other charges described in Paragraph 1 (b) (ii) and (iii) for emergency care following an accident.

(b) The maximum allowance for an Employee for all treatment and diagnostic services of subparagraph (a) above arising out of the same condition will be $800 for any calendar year. The maximum aggregate allowance for all such treatment and diagnostic services for each dependent of an Employee will be $800 for any calendar year.

(c) Benefits will be paid for charges made for x-ray, radium and radioactive isotopic therapy wherever performed. Payments for such charges will be made only if such treatment is authorized by a doctor licensed to practice medicine and will be limited to an aggregate

maximum of $2,500 for treatments of the same condition for any calendar year for the Employee or any of his dependents.

3. Surgical Benefits for Employees and Dependents

(a) Surgical Services

Benefits will be provided for surgical services consisting of operative and cutting procedures (including the usual postoperative care) arising from an accident or sickness not covered by a Workers' Compensation Act. Such services may be performed in or out of a hospital by a doctor licensed to practice medicine. Benefits will also be provided for:

(1) Surgical services performed by a doctor of surgical chiropody (D.S.C.) acting within the scope of his license, which are described in the Schedule of Surgical Operations—Chiropody (made a part hereof by reference).

(2) Obstetrical services, including necessary prenatal and post-natal care, for pregnancies of female Employees and wives of Employees.

(3) Non-operative procedures performed in lieu of surgery by a doctor licensed to practice medicine which are described in the "Schedule of Miscellaneous Specific Therapeutic Procedures" (made a part hereof by reference).

(4) The administration of anesthetics, except local infiltration anesthetic, other than in a hospital in connection with surgical or obstetrical services for which benefits are provided under the Program, when administered and billed by a doctor licensed to practice medicine (other than the operating surgeon or his assistant) who is not an employee of, nor compensated by, a hospital, laboratory, or other institution.

(5) Preparation of casts, made of plaster and other synthetic molded materials, required for medical treatment.

(6) Facility charge of a free standing surgical center in connection with a surgical procedure for which benefits are payable under this paragraph (a).

(7) Medical services and supplies when rendered by a doctor and are needed and consistent with the treatment for which care is being rendered for the following:

(i) Charges made by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) for emergency care rendered in a medical facility or physician's office following an accident.

(ii) Special bandages, crutches, braces, trusses, and sprints, including services related to the initial fitting and adjustment of these items,

when provided and charged by a hospital or other qualified personnel.

When the surgical services are performed on an in-patient of a hospital, benefits will also be provided for the services of a doctor licensed to practice medicine who actively assists the operating surgeon in the performance of such surgical services when the type and complexity of the surgical service and the condition of the patient requires such assistance and when the hospital does not have an approved intern or resident training program or a house officer or does not have surgical assistance routinely available as a service provided by a hospital intern, resident, or house officer.

(b) Second Surgical Opinions

Benefits will be provided for examinations for second surgical opinions in connection with a non-emergency surgical procedure. A non-emergency surgical procedure is defined as a procedure which may be scheduled at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

4. Reasonable and Customary Fee

Whenever benefits are provided in accordance with the foregoing Paragraph 3 of this Exhibit B-1, the amount of any such benefit will be determined on the basis of a reasonable and customary fee for the services performed.

This means that, subject to any maximums specified in this Exhibit B-1, and other limitations of the Program, the Program will pay the charges of the doctor for the service performed, but not more than the reasonable and customary fee. The carrier will determine the reasonable and customary charge for the procedure and, normally, payment will be made directly to the doctor.

In determining the reasonable and customary fee, the following will be considered:

(a) The usual fee which the individual doctor most frequently charges the majority of his patients for a like service or procedure.

(b) The prevailing range of fees in an area charged by most doctors of similar training and experience for a like service or procedure. An area may be a municipality or, in the case of a large city, a subdivision thereof, or such greater area as is required to determine prevailing charges.

(c) Unusual circumstances or medical complications requiring additional time, skill or experience.

If a charge appears to be excessive, the carrier will take appropriate steps to obtain information and medical advice which might support the additional amount. It will accept the recommendations of independent professional sources such as Medical Society Review Committees. If the charge still appears to be excessive, it will take every reasonable action to resolve it without

residual payment by the Employee, including assistance with respect to the defense of a legal proceeding. If an Employee (dependent) contracts with a doctor for a charge in excess of a reasonable amount, as determined by the carrier, the Program will not pay such excess.

An Employee who is required to appear and defend against a civil action instituted by a doctor for collection of a fee in excess of "reasonable and customary" fee shall be compensated for time lost from his regular scheduled shift. The rate of pay shall be "actual hourly earnings" as determined in accordance with Article VIII, Section 10(b) of the Basic Agreement.

5. Hospital-Medical Benefits for Employees and Dependents

Benefits will be paid for visits during a hospital confinement by a doctor licensed to practice medicine.

The amount of the benefit will be the fee charged by the doctor up to $70.00 for the first day of confinement that he makes one or more calls and $35.00 for each day that he makes one or more calls during the next 729 days of the same confinement. Benefits will not be payable for calls made at time of an operation, or obstetrical procedure or for calls made after an operation or obstetrical procedure if due to the condition which caused the operation or obstetrical procedure unless such calls were during a subsequent confinement separated by a non-confinement period of at least 7 days.

There is no limit to the number of periods of hospital-medical services for which benefits will be paid if the confinements are due to different causes, or if they are separated by complete recovery or by a period of 90 days, or, in the case of an Employee, if they are separated by a return to full-time work.

Benefits shall also be provided for the first routine hospital visit to a newborn child by a physician. The amount of the benefit shall not exceed $70.00

6. Post-Hospital Benefits

(a) Convalescent Nursing Unit Care

(1) Charges made by an approved Convalescent Nursing Unit for room and board will be paid providing the Employee or his dependent has been confined in a hospital for at least 3 days and then admitted to such Convalescent Nursing Unit within 21 days following the hospital confinement upon the written recommendation of the attending physician certifying that the patient's condition would require hospital confinement if Convalescent Nursing Unit care were not available. Re-admission, upon the attending physician's recertification, to such Convalescent Nursing Unit within 14 days following discharge will be considered a continuation of the same confinement for purposes of this Paragraph 6(a).

(2) The maximum daily allowance for all such board and room charges will be the charge actually made by the Convalescent Nursing Unit but not more than 50% of the daily rate which, immediately prior to such transfer, was being charged for semi-private room and board by the hospital from which the patient was transferred. Such allowance shall be paid only so long as the attending physician certifies that hospital confinement would continue to be necessary if Convalescent Nursing Unit care were not available. The maximum period for which an allowance will be paid for charges arising from any one cause will be the lesser of (a) 100 days and (b) the excess of the maximum number of days for which Hospital Expense Benefits are available under the applicable provisions of this Exhibit B-1 over the number of days of hospital confinement for such cause for which Hospital Expense Benefits were payable.

(3) The term "Convalescent Nursing Unit" means a licensed institution approved by the Social Security Administration pursuant to Title XVIII (Health Insurance for the Aged) of the Social Security Act, as amended in 1965. The term "Convalescent Nursing Unit" shall also include those institutions listed as "Extended Care Facilities" in the list titled "Accredited Extended Care Facilities" issued by the Joint Commission on Accreditation

of Hospitals as it may be amended from time to time. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, or as a facility for the aged or for the care of drug addicts or alcoholics.

(b) Visiting Nurse Service

Charges will be paid when an Employee or dependent receives medical treatment in his home by a Registered Nurse (RN) or a Licensed Physical Therapist employed regularly by an approved Visiting Nurse Service when medically necessary and ordered in writing by the attending physician.

The allowance for Visiting Nurse Service charges shall be the standard charge of the Visiting Nurse Service but shall not exceed $45.00 for each day such services are rendered to a maximum of 100 days for any one cause during any calendar year. Such allowance shall be paid only so long as the attending physician certifies such medical treatment to be necessary.

The term "Visiting Nurse Service", as used herein, means an organization or agency which meets all of the following requirements:

(1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing

authority to provide nursing and other therapeutic services,

(2) Its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse to govern the services provided,

(3) It provides for full-time supervision of such services by a registered nurse and has an administrator, and

(4) It maintains a complete medical record on each patient.

7. Prescription Drug Benefits

(a) General

Prescription drug benefits will be payable if an Employee or Dependent, as a result of an accident or sickness, incurs expenses for covered prescription drugs dispensed by any person or organization legally licensed to dispense drugs, upon the order of a physician licensed to practice medicine.

(b) Benefits

(1) Benefits will be provided through participating providers who have agreed to accept an assignment of the benefit claim hereunder by the Employee to the provider plus a co-payment by the Employee or Dependent of $5.00 as full payment for the covered prescription drug. The co-payment amount of $5.00 is to be paid by the Employee or his Dependent and is

applicable to each separate prescription order and to each refill thereof.

(2) Maintenance drug requirements may be filled through the Mail-Order Prescription Service established by the Company in which case the $5.00 co-payment is waived.

(3) Benefits will also be provided through a local pharmacy or pharmacies who have agreed to enter into a preferred provider agreement, as approved by the Company, and referred to as a Super PPO. When prescription drug requirements are filled through the Super PPO, the $5.00 co-payment is waived.

(4) If a covered prescription drug is dispensed by a non-participating provider, the amount of the benefit for each separate prescription order and each refill thereof will be:

(i) The dispensing fee for the covered prescription drug which the individual provider most frequently charges his customers for dispensing similar drugs, plus

(ii) the actual cost of the covered prescription drug to the provider, plus

(iii) any applicable state sales tax for the covered prescription drug, less

(iv) $5.00

(5) Notwithstanding the above benefit provisions, if the physician authorizes a generic medication to be dispensed and the patient insists on a name brand drug, the reimbursement shall be limited to the amount payable if the generic drug had been dispensed.

(c) Covered Prescription Drugs

The prescription drugs covered by this Paragraph 7 are:

(1) Injectable insulin, or any Prescription Legend Drug for which a prescription is required;

(2) A compound medication of which at least one ingredient is a Prescription Drug; and

(3) Any other drug which under the applicable state law may only be dispensed upon the prescription of a physician;

Provided that a prescription drug shall not be covered under this Paragraph 7 if (i) the cost thereof is included in the cost of other services or supplies provided to or prescribed for the Employee or his dependent, or (ii) such drug is consumed at the time and place the prescription is ordered; except, however, a drug dispensed by a licensed pharmacy doing business with the public will be covered.

"Prescription Legend Drug" means for the purpose of this Paragraph 7, any medical

substance, the label of which, under the Federal Food, Drug, and Cosmetic Act, as from time to time amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription".

(d) Exclusions

(1) No benefit shall be payable to an Employee or his Dependent if he is entitled to receive reimbursement under any Workers' Compensation Laws or is entitled to benefits from any municipal, state, federal or other governmental program of any sort.

(2) No benefit shall be payable for any medication or device which is to be used for contraceptive purposes, or for any therapeutic device or appliance (e.g., hypodermic needles, syringes, support garments and other non-medicinal substances).

(3) No benefit shall be payable for the administration of any medication.

(4) No benefit shall be payable for any medication for which the customary and usual charge is less than $5.00.

(5) No benefit shall be payable for more than a 100-day supply of any medication, for any refill in excess of the number specified by the physician, or for any refill dispensed after one year from the physician's order.

8. Benefits for Chiropractic Services

The Employer will provide the following benefits for chiropractic services for eligible Employees and their dependents as follows:

(a) Benefits will be paid for charges for chiropractic services of manipulations or adjustments for the treatment of non-occupational neuromusculoskeletal conditions which are performed by and during a visit to a duly licensed Chiropractor (D.C.) or Doctor of Osteopathy (D.O.) practicing within the scope of their license, subject to a maximum of 30 visits per calendar year per individual. The allowance per visit will be determined on the basis of a reasonable and customary fee for the services performed.

(b) Benefits will also be paid for charges incurred for X-rays made during any such visit when necessary for the diagnosis and analysis of such neuromusculoskeletal conditions. The amount of the benefit will be the reasonable and customary fee for such X-rays by Chiropractors (D.C.) or Doctors of Osteopathy (D.O.). The maximum allowance for all such X-rays arising out of the same condition will be $100 for each Employee or dependent of an Employee during a calendar year.

9. Eligibility for Benefits under Exhibit B-1

(a) Active Employees on the Effective Date, will be covered by the provisions of this Exhibit B-1 on that date. Employees not actively at work on the Effective Date, will be covered

by the provisions of this Exhibit B-1 immediately upon their return to work, but, until such return to work, will have such coverage for hospital expense, surgical, hospital-medical and prescription drug benefits, if any, and for such period of time as is provided for them in the plan in effect prior to the Effective Date.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

(b) Employees hired after the Effective Date, will become covered by the provisions of this Exhibit B-1 on the 31st day of employment.

(c) Coverage for an Employee's dependents will become effective on the same date as the Employee's coverage except that if a dependent, other than a new-born baby, of an Employee hired after the Effective Date, is confined in a hospital when the coverage for that dependent would otherwise become effective, the coverage will become effective upon final discharge from the hospital.

(d) An Employee's dependents are:

(i) The spouse, and unmarried children of the Employee under 19 years of age.

(ii) Unmarried children of the Employee who are eligible as dependents may continue to be deemed eligible dependents

of the Employee beyond age 19 provided such children upon attainment of age 19 are both dependent upon the Employee, and either:

(a) mentally or physically incapable of self-support, or

(b) a full-time student.

Extended eligibility as a dependent beyond age 19 will terminate when the Employee's child is:

(a) no longer mentally or physically incapable of self support as a result of the disability which gave rise to the original extension of coverage. In the case of a child who is no longer mentally or physically incapable of self-support, the child may again be deemed to be an eligible dependent as mentally or physically incapable of self-support if the child otherwise meets the requirements of this subparagraph (d) and, within 24 months following the date the child ceased to be eligible for coverage, re-qualifies as a child mentally or physically incapable of self-support as a result of the disability which gave rise to the original extensions of coverage, or

(b) no longer a full-time student. In the case of a full-time student, the child who attains age 19 or ceases to be a

full-time student, may again be deemed to be an eligible dependent as a full-time student if the child otherwise meets the requirements of this subparagraph (d) and within 24 months following the date the child ceased to be a full-time student, requalifies as a full-time student.

(iii) The donor of an organ for transplant, when the recipient is covered for hospital, surgical, and medical benefits under this Exhibit B-1, shall also be covered for such benefits as though he were a covered dependent child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor.

The word "child" in addition to the Employee's own children includes such stepchildren, foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, or marriage, such dependent shall not become eligible until three months have elapsed from the date such child was added to the Employee's enrollment record.

10. Layoff

(a) In the event of layoff, coverage under this Exhibit B-1 will be continued without cost to the Employee for 90 days following layoff.

(b) Thereafter, coverage will be continued without cost to the Employee for a period during which he is laid off for one of the reasons set forth in Article I, Section 4(a) of the Goodyear Supplemental Unemployment Benefits Plan maintained by the parties hereto under Agreement as amended on May 15, 1991, and with respect to which he receives no earnings for work performed for the Employer; but the maximum period of such continued coverage shall be determined in accordance with the following table:

Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him	**Maximum Number of Months for which Hospital, Surgical, Medical, Dental, Prescription Drug and Major Medical Coverages Will Be Continued Without Cost to Employee**
16-19	1
20-23	2
24-27	3
28-31	4
32-35	5
36-39	6
40-43	7
44-47	8
48-52	9

(i) In applying the above table, the "Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as

of Last Day Worked Prior to Layoff Would Entitle Him" shall be determined by dividing the number of the Employee's Credit Units under the Supplemental Unemployment Benefits Plan by the number of Credit Units to be cancelled for one SUB Benefit in accordance with the Credit Unit Cancellation table contained in Article III, Section 4 of such Supplemental Unemployment Benefits Plan, based on the Employee's seniority and the Trust Fund Position in effect as of the last day worked prior to layoff. The "Maximum Number of Months for Which Hospital, Surgical, Medical, Dental, Prescription Drug and Major Medical Coverages Will Be Continued Without Cost to Employee" shall commence with the 91st day of layoff.

(ii) With respect to any period of continuous layoff, changes in an Employee's Credit Units, Seniority or Trust Fund Position subsequent to the date layoff begins shall not change the number of months of continued coverage for which such Employee is eligible.

(iii) In the event that the aforesaid Goodyear Supplemental Unemployment Benefits Plan shall be terminated in accordance with its terms prior to the termination of this Agreement, Subparagraph (b) of this Paragraph 10 shall thereupon cease to have any force or effect.

(iv) The foregoing provisions of this Subparagraph (b) shall be subject to the Employer obtaining and retaining from the Commissioner of Internal Revenue and from the United States Department of Labor the rulings referred to in the Agreement between the parties of May 15, 1991 relating to Supplemental Unemployment Benefits, and shall be effective with respect to layoffs commencing on or after the first day of the month following the month in which such rulings are received by the Employer. Pending receipt of said rulings the foregoing provisions of this Subparagraph (b) will nevertheless be made operative as to any Employee for a period up to 90 days.

(c) The maximum period of coverage under this Paragraph 10 shall be 24 consecutive months following the month in which the Employee was laid off. For any month in this period not covered by Employer-furnished coverage the Employee may continue the coverage by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage.

(d) An Employee on layoff may not continue his coverage as provided in (c) above while covered by any other employer-furnished noncontributory hospital, medical and surgical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the 24-month maximum period.

In order to remain eligible for continued coverage as provided in (c) above, the Employee must maintain such coverage continuously except as provided above in this Subparagraph (d).

(e) Employees re-employed with credit for prior service will have an immediate reinstatement of coverage.

(f) An Employee on layoff eligible for coverage under this Paragraph 10 upon acceptance of a Separation Payment under Article XIII of the 1950 Pension Plan shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this Paragraph 10.

11. Leave of Absence, etc.

(a) During authorized leave of absence, (other than leaves for which coverage is provided in sub-paragraphs (b), (c) and (d) below) coverage under this Exhibit B-1 will be continued for a period not to exceed 90 days. Employees on leave of absence extending beyond such 90 day period, may, by application to the Employer during such period and payment of current group rate premium, continue such coverage during the period of such leave of absence. An Employee who leaves the employ of the Employer as the result of being elected or appointed to public office, or to an office in a Local Union cooperative enterprise serving Company employees, may, by application to the Employer prior to

leaving his employment with the Employer and upon payment of the current group rate premium, continue such coverage during the period of his service in such office.

(b) During an authorized leave of absence for active duty in Armed Forces for a period of less than six months, an Employee (and his eligible dependents) shall continue to be eligible for the benefits provided in this Exhibit B-1 to the extent that such benefits are not provided by the Military Service or the Federal or State Government.

(c) During an authorized leave of absence for pregnancy, Employees (and their eligible dependents) will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

(d) Notwithstanding the foregoing, coverage shall be continued without cost to the Employee during the period of an Employee's authorized leave of absence granted by his Employer for service with a local Union in an official or representative capacity or while representing such local Union in a State, County, or City council of AFL-CIO-CLC.

12. Injury or Sickness

Employees off work due to injury or sickness will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

13. Termination of Coverage Under Exhibit B-1

Except as described in Paragraphs 10, 11, and 12 immediately above, all coverage will terminate when active employment with the Employer terminates except as follows:

(a) The hospital, surgical, hospital-medical, dental, prescription drug and major medical benefits for an Employee or dependent will be extended for three months following termination of coverage to cover a hospital confinement, an operation or obstetrical procedure resulting from a continuous total disability which began while the coverage was in force.

(b) Coverage will be extended for three months for the spouse and dependent children of an Employee who dies while on the payroll of the Employer, while on sick leave (and accumulating seniority), while on layoff with Exhibit B-1 coverage provided continuously under Paragraph 10 of this Exhibit B-1, during authorized leave of absence for a period not to exceed 90 days, or while on authorized leave of absence for service with a Local Union in an official or representative capacity.

The surviving spouse of a deceased Employee who is not eligible for continued coverage under Paragraph 15 (b) of this Exhibit B-1 may elect, within such 90 days, to extend such coverage for up to an additional 21 months by payment in advance of the current group rate premium. Such spouse may make arrangements for the premium to be

paid (i) in a lump sum amount equal to 17 monthly payments which may be deducted from any benefits the spouse is entitled to receive under Section A, Life Insurance or (ii) in quarterly installments paid directly to the Company.

(c) Coverage for an unmarried full-time student will be extended for 90 days following termination of status as full-time student provided no other group medical coverage of any kind is in effect on such student.

(d) Where practicable the Employer will arrange with an insurance company for issuance of individual policies of medical expense benefits without medical examination when elected by an individual whose coverage terminates as provided in Paragraphs 10, 11, 12 and this Paragraph 13 or with respect to a child who no longer meets the eligibility requirements of this Exhibit B-1. Issuance of such an individual policy will be subject to the following:

(i) the Employee has been covered for 3 or more months under Exhibit B-1, and

(ii) a written application and payment of the first 3 months' premium is made within 31 days following termination of coverage under Exhibit B-1, and

(iii) the individual policy will be one of the policies issued by the insurance company for conversion purposes and subject to the terms and conditions of said policy.

14. Employees Retired on Pension

Employees who retire with 10 or more years of continuous service and who are eligible and receiving a monthly pension under the 1950 Pension Plan for a pension (other than a deferred vested pension), shall receive the benefits described in this Exhibit B-1; provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

Employees who retire with less than 10 years of continuous service and who are eligible and receiving a monthly pension under the 1950 Pension Plan for a pension (other than a deferred vested pension) may elect to receive the benefits described in this Exhibit B-1 by payment in advance of the Group Rate as estimated by the Company annually in advance.

Employees hired after April 23, 1988 and who retire after completion of at least 20 years of continuous service and who are eligible and receiving a monthly pension under the 1950 Pension Plan for a pension (other than a deferred vested pension), shall receive the benefits described in this Exhibit B-1.

Employees hired after April 23, 1988 and who retire after completion of at least 10 years of continuous service but less than 20 years of continuous service and who are eligible and receiving a

monthly pension under the 1950 Pension Plan for a pension (other than a deferred vested pension), shall receive benefit amounts equal to 50% of the benefits described in this Exhibit B-1; provided, however; that such retired employee may elect to continue the full benefits of this Exhibit B-1 by payment in advance of 50% of the Group Rate as estimated by the Company annually in advance.

15. Survivor Benefits

(a) The surviving spouse of (i) a deceased Employee who retires on or after the Effective Date, and was eligible for and receiving a monthly pension (other than a deferred vested pension), and (ii) a former Employee whose employment was terminated on or after the Effective Date, at or after attainment of age 60 and who dies after he has commenced to receive a deferred vested pension, shall be entitled to continue to receive the benefits of this Exhibit B-1 until death or remarriage under the exact same conditions and amounts that such surviving spouse was entitled to such benefits as a dependent immediately prior to the death of such former Employee, provided such surviving spouse was either an eligible spouse at the time of the Employee's retirement or had been legally married to the Employee for at least 12 consecutive months preceding his death.

Also, the surviving dependent of an Employee who is retired by the Employer and receiving a monthly pension (other than a deferred vested pension) on or after the Effective

Date, provided such dependent as of the date of the death of such retired Employee was covered by these benefits as an eligible dependent, shall continue to be eligible to receive the exact same benefits and under the same conditions so long as the dependent continues to qualify as such, provided such surviving dependent was either an eligible dependent at the time of the Employee's retirement or was also a dependent of a surviving spouse who had been legally married to the Employee for at least 12 consecutive months preceding his death.

(b) The benefits provided under this Exhibit B-1 shall continue for the spouse and dependents of an Employee who had (i) attained age 55 or more and had 10 or more years of continuous service or (ii) 20 or more years of continuous service, and who dies and at the date of death was eligible for said benefits, was on the payroll of the Employer, was on sick leave (and accumulating seniority), was on layoff with Exhibit B-1 coverage provided continuously under Paragraph 10 of this Exhibit B-1, was on authorized leave of absence for period not to exceed 90 days, or was on authorized leave of absence for service with a Local Union in an official or representative capacity. Such coverage shall terminate when spouse remarries or dies; provided that such coverage for each such dependent shall continue after the death of the spouse (if the spouse has not remarried) so long as the dependent continues to qualify as such (but for

being dependent on the Employee) under (i) or (ii) of Paragraph 9(d) of this Exhibit B-1.

16. Special Medicare Benefit

(a) Eligibility for Benefit

An Employee, Pensioner or eligible Surviving Spouse, and their eligible dependents, who are eligible for benefits under this Exhibit B-1 will be eligible for a Special Medicare Benefit upon (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, when first eligible to enroll in Part B of Medicare with Medicare as primary coverage.

(b) Amount of Benefit

The amount of the Special Medicare Benefit will be equal to the lesser of the standard monthly premium for Part B of Medicare or $42.00 that is paid by persons who enroll when first eligible for primary Medicare coverage but shall not include any additional premiums such as those charged for delinquent enrollment.

(c) Payment of Benefit

The Special Medicare Benefit will be paid to the Employee, Pensioner or eligible Surviving Spouse. Payment of the Special Medicare Benefit will commence on the first day of the month following (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is

prior to age 65, or (iii) if earlier, the first day of the month following the month for which such individual is eligible to enroll in Part B of Medicare with Medicare as primary coverage.

Payment of the Special Medicare Benefit shall continue so long as the Employee, Pensioner or eligible Surviving Spouse and the eligible dependents continue to be covered for benefits under this Exhibit B-1 and continue to be eligible for coverage under Part B of Medicare.

The Special Medicare Benefit will not be paid for any eligible dependent who is also eligible for this Special Medicare Benefit as an Employee, Pensioner or Surviving Spouse or when such dependent is reimbursed by another employer for the Medicare Part B premium. When a dependent child is covered by this Paragraph under more than one Employee or Pensioner, the Special Medicare Benefit will be paid only to the male Employee or Pensioner.

* * *

26. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 26 is provided in lieu of all other coverage under Part V, Section A of the Agreement and this Exhibit B. However, upon termination of coverage under this Paragraph 26, the conversion privileges of Part V, Section A,

Paragraph 1 of the Agreement and Exhibit B-1, Paragraph 13(d) and the termination provisions of Exhibit B-1, Paragraph 13 shall apply.

Coverage under Part V, Section A of the Agreement will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of Section A. Coverage under Exhibit B will be extended following such Plant Closure without cost to the Employee for an additional 12 months beyond Employer-furnished coverages provided in Paragraph 10 of Exhibit B-1. However, in no event shall the coverage provided in Paragraph 10(b) of Exhibit B-1 be less than 9 months. For any month in which Employer-furnished coverage is provided under Part V, Paragraph 1 of the Agreement, the Employee may continue to purchase coverage under Paragraph 2 of Section A.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Goodyear Supplemental Unemployment Benefits Plan, coverage under Exhibit B may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 26 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 of the Agreement and 36 consecutive months for coverage under Exhibit B following the month in which such Plant Closure occurred.

Coverage under this Paragraph 26 will not continue as provided above while the Employee is covered by any other employer sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 26.

AGREEMENT

Between

The Goodyear Tire and Rubber Company
Point Pleasant Polyester Plant

and

Local No. 644

of the

United Rubber, Cork, Linoleum and
Plastic Workers of America
A.F.L.-C.I.O.

Effective November 6, 1991

* * *

ARTICLE XV
EFFECTIVE DATE
AND TERMINATION

Section 1

This Agreement shall become effective **November 6, 1991** and shall continue in effect until 12:01 a.m. **November 6, 1994**. Thereafter it shall renew itself for yearly periods unless written notice is given by either party to the other not less than sixty (60) days but not more than seventy-five (75) days prior to the expiration date or any extension thereof that is desired to terminate or amend the Agreement. In the event such notice is given, the parties shall begin negotiations within forty-five (45) days prior to 12:01 a.m. November 6, 1994. At the opening of such negotiations both parties shall present to each other in writing their proposed changes in said Agreement.

If negotiations are not completed prior to the expiration date, this Agreement shall terminate unless extended by mutual agreement of the parties.

Section 2

In the event that right, title or possession to the plant covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale or any other method of disposition or acquisition, this Agreement shall be binding upon the Company and its successors and assigns.

* * *

LETTERS OF INTENT

Letter A

June 27, 1991

Mr. Don Rollins
United Rubber, Cork, Linoleum and
Plastic Workers of America
AFL-CIO,Local 644

Dear Mr. Rollins:

This letter replaces the letter from J M Roberts to R E Allbright dated November 6, 1988 as set forth on page 107 of the Agreement between the parties dated November 6, 1988.

It is recognized by the parties that for the duration of this agreement all the terms and conditions of the Pension, Insurance and Service Award Agreement of May 15, 1991, as from

time to time amended, between the Goodyear Tire and Rubber Company and the United Rubber, Cork, Linoleum and Plastic Workers of America, including the covering letters under the same date, will be applied to the employees covered by this Agreement with the exception of letter (7), letter (8) and further letter (21) and letter (22) will be applied in the following manner at the Point Pleasant Plant.

* * *

Sincerely,

J. M. Roberts
Manager Industrial Relations

Agreed _____
Don Rollins
President, Local 644

PENSION, INSURANCE AND SERVICE AWARD AGREEMENT
Effective July 20, 1994
Between
THE GOODYEAR TIRE & RUBBER COMPANY
and
UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC INTERNATIONAL UNION, AND LOCAL UNIONS NO. 2, AKRON & STOW, O; NO. 12, GADSDEN, ALA.; NO. 200, ST. MARY'S, O; NO. 286, LINCOLN, NEB; NO. 307, TOPEKA, KAN; NO. 831, DANVILLE, VA; NO. 843, MARYSVILLE, O; NO. 878, UNION CITY, TENN; NO. 904; SUN PRAIRIE, WISC.

* * *

EXHIBIT B-1

THE GOODYEAR TIRE & RUBBER COMPANY COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January , 1995, and for the duration of this Agreement thereafter, the Employer will provide the following program of hospital benefits, hospital-medical benefits, surgical benefits and prescription drug benefits for eligible employees and their dependents, with the exception that none of the aforesaid benefits shall be applicable in the event of accident or sickness covered by a Workers' Compensation Act nor shall there be any duplication of benefits under any Employer-sponsored Program.

* * *

SUPPLEMENTAL PENSION, INSURANCE AND SERVICE AWARD AGREEMENT

Effective July 20, 1994

Between

THE GOODYEAR TIRE & RUBBER COMPANY

and

UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC INTERNATIONAL UNION, AND LOCAL UNIONS

NO. 2, AKRON & STOW, O; NO. 12, GADSDEN, ALA.; NO. 200, ST. MARY'S, O; NO. 286, LINCOLN, NEB; NO. 307, TOPEKA, KAN; NO. 831, DANVILLE, VA; NO. 843, MARYSVILLE, O; NO. 878, UNION CITY, TENN; NO. 904; SUN PRAIRIE, WISC.

* * *

FOREWORD

The following pages contain the Supplemental Pension, Insurance and Service Award Agreement dated July 20, 1994, by and between The Goodyear Tire & Rubber Company and United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO-CLC International Union, and the Local Unions thereof listed therein, effective July 20, 1994.

This Agreement establishes the Medical Necessity Benefits Program, Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions.

SUPPLEMENTAL PENSION, INSURANCE, AND SERVICE AWARD AGREEMENT

THIS AGREEMENT is made and entered into this 20th day of July, 1994, by and between THE GOODYEAR TIRE & RUBBER COMPANY, covering the plants operated by it as listed below, and UNITED RUBBER CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC INTERNATIONAL UNION, and the local unions thereof listed below.

Whenever used in this Agreement:

(a) The term "Basic Agreement" means the present agreement dated July 20, 1994, between the parties hereto, or any new agreement replacing such present agreement, hereafter entered into between the parties hereto; and the term "1991 Agreement" means the Pension, Insurance and Service Award Agreement entered into between the parties on May 15, 1991;

(b) The terms "Company" and "Employer" each mean The Goodyear Tire & Rubber Company;

(c) The term "Employee" means any employee of the Employer who, during the term of this

Agreement, shall be in a bargaining unit covered by the Basic Agreement;

(d) the term "Union" means the United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO-CLC International Union; and

(e) The term "Local Union" means, as to each plant covered by this Agreement, the respective local union listed below which is the exclusive bargaining agency of the employees in certain bargaining units at such plant.

This Agreement is executed by representatives of the Union and by members of the International Policy Committee who represent the Local Unions involved.

The plants covered by this Agreement and their respective Local Unions are as follows:

Plant	Local Union
Akron and Stow Plants	2
Gadsden Plant	12
St. Mary's Plant	200
Lincoln Plant	286
Topeka Plant	307
Danville Plant	831
Marysville Plant	843
Union City Plant	878
Sun Prairie Plant	904

PART I
PLANT CLOSURE

1. It is agreed that "Plant Closure" wherever used in this Agreement shall mean when operations at a plant covered by this Agreement shall be completely and permanently discontinued while this Agreement is in force.

2. In the event a product commodity line or lines is permanently discontinued at a plant covered by this Agreement while it is in force and results in the layoff of ten percent (10%) or more of the total work force and has continued for at least one year, and it has been determined that there is no reasonable likelihood that the employees on layoff will be recalled, the Employer and Local Union will meet to discuss the possible application of the Plant Closure provisions of the Agreement to the employees involuntarily laid off. The one-year period may be shortened by agreement of the parties.

PART II
MEDICAL BENEFITS AND SAVINGS PLAN

SECTION A – Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions

Effective January 1, 1995, and for the duration of this Agreement thereafter, the Employer will provide a Medical Necessity Benefits Program and Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions as described in

Exhibit A attached hereto and made a part hereof by reference.

Each Employee who was covered under the provisions of Exhibit B of the Pension, Insurance and Service Award Agreement dated May 15, 1991 shall be covered under the provisions of this Agreement.

Each active Employee who is covered under the provisions of this Agreement shall be afforded, on an annual basis, the opportunity to be covered under the provisions of Exhibit B of the Pension, Insurance and Service Award Agreement dated July 20, 1994. If benefits are elected under the above described Exhibit B, an Employee may not subsequently elect to be covered under this Agreement.

An Employee covered by this Agreement who is not actively at work on the Effective Date shall make his election of benefits coverage immediately on his return to work.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift or not actively at work because of a temporary disability.

An Employee hired after the Effective Date shall make his election of benefits coverage prior to his 31st day of employment. The Employee may elect to be covered under the provisions of Exhibit B of the Pension, Insurance and Service Award Agreement

dated July 20, 1994 or under the provisions of this Agreement.

If on the 31st day of employment for an Employee who was hired after the Effective Date, the Employer has not received an election of benefits coverage from an Employee, such Employee will be deemed to have elected to be covered under the provisions of Exhibit B of the Pension, Insurance and Service Award Agreement dated July 20, 1994.

An Employee who retires and receives a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan) and is eligible for benefits under Exhibit A shall have his medical benefits after retirement provided under Exhibit A, provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Consistent with the provisions of COBRA, and any subsequent amendments thereto, the Company will make available the options for continuation of health care coverage prescribed by COBRA, to employees, spouses, former employees, former spouses and former

eligible dependents. The medical benefit continuation options prescribed by COBRA shall be concurrent with any continuation of benefits otherwise provided in this Section A and Exhibit A-1.

SECTION B – Dental Benefits for Employees and Dependents

Effective July 20, 1994 and for the duration of this Agreement thereafter, benefits will be payable for eligible charges which are incurred in connection with a non-occupational accident or illness of an Employee or eligible dependent for Endodontic, Periodontic and Oral Surgery procedures, performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medicine (M.D.) acting within the scope of his license, which are described in the Schedule of Dental Procedures (made a part hereof by reference).

Benefits will also be paid for such eligible charges which are for treatment of a fractured jaw or of accidental injuries to

natural teeth within 12 months of the accident (including replacement of such natural teeth within such period).

Whenever benefits are provided in accordance with the foregoing Paragraphs, the amount of any such benefit will be determined on the basis of a reasonable and customary fee for the services performed.

Coverage and eligibility for dental benefits under this Section B will be in accordance with the coverage and eligibility provisions contained in Exhibit A-1.

SECTION C – General Provisions For Part II, Sections A and B

1. Listing of Dependents

   Each Employee shall furnish a list of his eligible dependents on an enrollment form supplied by the Employer for such purpose. This form must be kept up to date at all times.

2. Definition of "Physician", etc.

   The term "physician", or "doctor" or "doctor licensed to practice medicine", or "doctor licensed to practice dental surgery" as used in this Part II means only a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) or a Doctor of Dental Surgery (D.D.S.), except that with respect to surgical operations coming within the scope of the "Schedule of Surgical Operations – Chiropody" the term also means a Doctor of Surgical Chiropody (D.S.C.) (Podiatrist) and with respect to chiropractic treatments for neuromusculoskeletal conditions coming within the scope of his license, the term shall also mean a Chiropractor.

3. Insurance Contracts

   The Employer may alone, or in conjunction with other corporations subsidiary to or affiliated with the Company, enter into a contract or contracts with an insurance company or insurance companies to provide the benefits described in this

Part II. No insurance company contract which may be entered into by the Employer for the purpose of providing any benefits described in this Part II shall alter, amend or detract from the provisions of this Agreement.

4. Grievance Procedure

If any difference shall arise between the Employer and any Employee with respect to whether or not the Employer has provided the benefits under this Part II, and if agreement cannot be reached between the Employer and such Employee, such difference may be taken up as a grievance under the grievance procedure provided for under the Basic Agreement at the Manager of the Labor Department level. If any such grievance shall be taken before the impartial umpire in accordance with such procedure, then the impartial umpire shall have the authority only to decide the question pursuant to the provisions of this Part II applicable to the question, but he shall have no authority in any way to alter, add to, or subtract from any such provisions. The decision of the impartial umpire shall be binding on the Employer, such Employee, and all other interested parties. Termination of the Basic Agreement shall not invalidate the use of its grievance procedure for the purposes of this Part II.

5. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 5 is provided in lieu of all other coverage under Part V, Section A of the Pension,

Insurance and Service Award Agreement dated July 20, 1994 and Exhibit A of this Agreement. However, upon termination of coverage under this Paragraph 5, the conversion privileges of Part V, Section A, Paragraph 1 of the Pension, Insurance and Service Award Agreement dated July 20, 1994 and Exhibit A of this Agreement as well as the termination provisions of Exhibit A shall apply.

Coverage under Part V, Section A of the Pension, Insurance and Service Award Agreement dated July 20, 1994 will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of said Section A. Coverage under Exhibit A will be extended following such Plant Closure without cost to the Employee for an additional 12 months beyond Employer-furnished coverages provided in Exhibit A. However, in no event shall the coverage provided in Exhibit A be less than 9 months. For any month in which Employer-furnished coverage is provided under Paragraph 1, Part V, Section A of the Pension, Insurance and Service Award Agreement dated July 20, 1994, the Employee may continue to purchase coverage under Paragraph 2 of Section A of said Agreement.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Goodyear Supplemental Unemployment Benefits Plan, coverage under Exhibit A may be continued up to an additional 12 months by payment

in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 5 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 of the Pension, Insurance and Service Award Agreement dated July 20, 1994 and 36 consecutive months for coverage under Exhibit A of this Agreement following the month in which such Plant Closure occurred.

Coverage under this Paragraph 5 will not continue as provided above while the Employee is covered by any other Employer sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 5.

PART III
DURATION AND TERMINATION

1. This Agreement shall become effective as otherwise set forth in this Agreement, upon approval by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union. Should this Agreement not have been approved by a majority of the Local Unions representing a majority of the membership and by the

International Executive Board of the International Union prior to August 10, 1994, all references in this Agreement (and the Exhibits hereto) to July 20, 1994, shall be construed to refer to the date as of which such approval is given.

2. This Agreement constitutes a settlement for the duration of this Agreement of all issues with respect to the subject matters covered hereby, and, while this Agreement continues in effect, the Employer shall have no obligation to negotiate or bargain with the International Union or any Local Union (except as noted in connection with grievance procedures) with respect to any subject matter covered hereby, nor shall there be any strike or work stoppage with respect to such matters. Any termination of the Basic Agreement in accordance with the provisions thereof shall not affect the duration of this Agreement nor shall such termination of the Basic Agreement be deemed to open for negotiation the subject matters covered by this Agreement. The fact that this Agreement continues in effect shall not prevent the parties from engaging in a strike or lockout with respect to any subject matter not covered by this Agreement, if such strike or lockout may be engaged in lawfully under the terms and provisions of the Basic Agreement.

3. The International Union, Local Unions and the Employer agree that this Agreement terminates on April 19, 1997 and shall not be continued beyond that date.

4. This Agreement may be amended by mutual agreement between the parties. If either party proposes amendments to this agreement during the life thereof, negotiations on such proposals shall begin within thirty (30) days. If no settlement is reached, the provisions of this Agreement shall continue in effect.

5. In the event that right, title or possession to any or all of the plants covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale, or any other method of disposition or acquisition. The benefits provided in this Agreement shall be binding upon the Company and its successors and assigns.

IN WITNESS WHEREOF THE PARTIES HERETO HAVE HEREUNTO SET THEIR HANDS THIS 20TH DAY OF JULY, 1994.

THE UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC

INTERNATIONAL UNION
(sgd)Kenneth Coss
(sgd)Ron Hoover
(sgd)W T Davenport

LOCAL UNION NO. 2, URCLPWA
(sgd)Dan Kelly, Sr
(sgd)William Demboski

LOCAL UNION NO. 12, URCLPWA

THE GOODYEAR TIRE & RUBBER COMPANY

(sgd)M L Burns
(sgd)J M Warren
(sgd)J F Kruse
(sgd)D F Neff
(sgd)J McElroy
(sgd)E D Wade
(sgd)C S Jerzyk
(sgd)P M Drabovzal
(sgd)T L Lammlein
(sgd)D H Smith

(sgd)J R Countryman
(sgd)George T. Booker Jr

LOCAL UNION NO. 200, URCLPWA
(sgd)Jim Clark

LOCAL UNION NO. 286, URCLPWA
(sgd)Jared F Teichmeier
(sgd)Sally Edwards

LOCAL UNION NO. 307, URCLPWA
(sgd)Don Northcraft
(sgd)George Amis

LOCAL UNION NO. 831, URCLPWA
(sgd)Danny Barber
(sgd)Benny Toller

LOCAL UNION NO. 843, URCLPWA
(sgd)John I Rutherford

(sgd)M J McColgan
(sgd)R L Ward
(sgd)J L Allen
(sgd)D T Shaffer
(sgd)J R Moyer
(sgd)S G Neely
(sgd)W B Miller
(sgd)C H Lyndon
(sgd)J A Czerviouke
(sgd)S E Brown

THE UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA, AFL-CIO-CLC

LOCAL UNION NO. 878, URCLPWA
(sgd)Sam Odom Jr
(sgd)Edd Ferrell

LOCAL UNION NO. 904, URCLPWA
(sgd)Jim Dushack

EXHIBIT A
MEDICAL NECESSITY BENEFITS PROGRAM
AND
MAJOR MEDICAL BENEFITS PROGRAM

EXHIBIT A-1
MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January 1, 1995, and for the duration of this Agreement thereafter, the Employer will provide the following Program of hospital benefits, hospital-medical benefits, surgical benefits, and prescription drug benefits subject to the Medical Necessity Review requirements of Paragraphs 1(c) with the exception that none of the aforesaid benefits shall be applicable in the event of accident or sickness covered by a Workers' Compensation Act nor shall there be any duplication of benefits under any Employer sponsored Program.

1. Hospital Expense Benefits For Employees and Dependents

   (a) General

   Benefits will be paid for hospital confinement due to an accident or sickness which is approved by a doctor licensed to practice medicine. In no event, however, will benefits be paid for rehabilitation treatment of drug addicts or alcoholics in a hospital, in a wing

or section of a hospital or in a facility connected with a hospital.

For semi-private accommodations the benefit for a certified day will be equal to the hospital's daily charge for room and board for a semi-private room.

For private accommodations for a certified day, an allowance will be paid equal to the hospital's average daily charge for room and board for a semi-private room.

No benefits will be payable unless the hospital makes a charge for board and room except as provided in Paragraph (b) following.

(b) Benefits

The following benefits are provided:

(i) Room and board benefits will be paid for both certified and non-certified days up to a maximum of 730 days for any one confinement. There will be no limit to the number of hospital confinements for which benefits are paid if they are due to different causes, or if they are separated by completed recovery or a period of 90 days, or, in the case of an Employee, if they are separated by return to full time work. This provision includes maternity benefits for female Employees and wives of Employees.

(ii) When there is a certified or non-certified hospital charge for room and board, additional benefits will be provided without

limit for the following: miscellaneous hospital-medical services and supplies, administration of anesthesia, ambulance service provided by any hospital or professional ambulance service and charges made by hospital-approved physicians or other medical technicians for services utilizing hospital equipment, when such services are not provided by the hospital or performed by members of the hospital's staff.

The term "miscellaneous hospital medical services and supplies" shall include bandages, crutches, splints, braces and trusses (including services related to initial fitting and adjustment of these items) when provided and billed by the hospital or other professional qualified personnel.

The term "miscellaneous hospital medical services and supplies" shall also include hospital charges for "supplementary medical service", "room and board supplement", "special room supplement", "isolation", "contagious", "intensive care", "cardiac care unit", or similar terms of like meaning if such services are, in fact, so billed and certified by the hospital to be hospital medical services and/or hospital medical supplies.

(iii) The benefits of sub-paragraph (ii) will also be paid when there is no hospital charge for room and board if the Employee

or his dependent receives electro-shock therapy in a hospital or is confined in a hospital either for an operation or for emergency care following an accident (including removal, wherever performed, of sutures, clamps, or casts supplied for treatment of injuries sustained in such accident). Such outpatient electro-shock therapy or emergency care for which benefits are payable shall include charges by a doctor where not routinely provided by the hospital provided such doctor personally treats the patient and is not an employee of the hospital.

(iv) When usual miscellaneous hospital medical services are not available in a hospital or when for other legitimate reasons a doctor decides to provide such services in the hospital, the charges will be paid, provided such charges do not exceed the usual hospital charges for such services.

(c) Hospital Admission Certification Provision

Whenever benefits are provided in accordance with subparagraphs (a) or (b) above, the amount of any such benefit payable will be subject to hospital admission certification approved by the Utilization Review Firm. Certification approval by the Utilization Review Firm will be required as follows:

(i) Non-emergency medical or surgical admission will require Pre-Admission Certification as to the need for confinement.

(ii) Emergency admission will require notification to the Utilization Review Firm within 48 hours after the admission (or if longer, on the first business day following a weekend or holiday admission) and certification approval as to length of stay. When an emergency admission confinement does not exceed 48 hours, certification approval by the Utilization Review Firm will not be required.

(iii) Certification approval of hospital confinement admission will require concurrent review certification as to the continued need for confinement and length of stay.

(iv) Pre-Admission Testing (PAT) under an approved PAT program at the hospital in which surgery is to be performed will be required on all non-emergency surgery.

When certification is required and the Utilization Review Firm does not grant such certification approval, the benefits otherwise payable in subparagraphs (a) and (b) above, will be provided as follows:

(i) 75% of the hospital's daily charges for the weekend days of Friday or Saturday when a non-emergency admission occurs on such days unless surgery was performed on such weekend days of Friday, Saturday or Sunday or it was medically necessary for the patient to be admitted on the weekend days of Friday or Saturday.

(ii) 75% of the hospital's daily charges for the days of any admission where required certification was not obtained.

(iii) 75% of the hospital's daily charges for any days following the initial certification of a specified number of days for which certification approval was not obtained.

(iv) 75% of the hospital's daily charges for room and board for the first certified day of confinement when an approved Pre-Admission Testing (PAT) program was available at the hospital and such PAT was not used unless due to medical reasons.

The required certification approvals described in this subparagraph will be made by a Physician Advisor of the Utilization Review Firm following a review and evaluation of medical information provided by the patient's attending physician or by the Utilization Review Firm using established medical criteria to determine medical necessity and appropriateness of the admission and proposed plan of treatment. If the patient's attending physician and the Utilization Review Firm's Physician Advisor are unable to reach agreement concerning the patient's need for hospital confinement or continued confinement, the need for such confinement will be decided by a "local panel" physician.

2. Outpatient Treatment and Diagnostic Services

(a) Benefits

(i) Charges directly connected with x-rays or fluoroscopy for diagnostic purposes will be paid wherever performed when authorized by a doctor licensed to practice medicine, a doctor of dental surgery, or a doctor of surgical chiropody.

Notwithstanding the above procedures done for diagnostic purposes in the event of accident or illness, charges will also be paid for:

(1) Routine PAP test,

(2) routine mammogram when performed once every two years between the age of 50 and 59 and annually upon the attainment of age 60.

(ii) Charges made for diagnostic laboratory tests will be paid wherever performed when authorized by a doctor licensed to practice medicine.

(iii) Charges made for diagnostic Computerized Axial Tomographic (CAT) scans or Magnetic Resonance Imaging (MRI) scans will be paid wherever performed when authorized by a doctor licensed to practice medicine. The charges for the first CAT scan or MRI scan performed on a patient during any calendar year will not be used in the computation of

the maximum annual allowance described in subparagraph (b) below.

(iv) Charges made for such medical tests as basal metabolism, electrocardiographs and electroencephalograms will be paid wherever performed when authorized by a doctor licensed to practice medicine.

(v) Charges made by a hospital for necessary medical care performed in the hospital's outpatient department for treatment of a physical disorder not arising from an accident when authorized by a doctor licensed to practice medicine. Such medical care shall include all the hospital-medical services and supplies and other charges described in Paragraph 1(b)(ii) and (iii) for emergency care following an accident.

(b) The maximum allowance for an Employee for all treatment and diagnostic services of subparagraph (a) above arising out of the same condition will be $800 for any calendar year. The maximum aggregate allowance for all such treatment and diagnostic services for each dependent of an Employee will be $800 for any calendar year.

(c) Benefits will be paid for charges made for x-ray, radium and radioactive isotopic therapy wherever performed. Payments for such charges will be made only if such treatment is authorized by a doctor licensed to practice medicine and will be limited to an aggregate maximum of $2,500 for treatments of the

same condition for any calendar year for the Employee or any of his dependents.

3. Surgical Benefits For Employees and Dependents

(a) Surgical Services

Benefits will be provided for surgical services consisting of operative and cutting procedures (including the usual post-operative care) arising from an accident or sickness not covered by a Workers' Compensation Act. Such services may be performed in or out of a hospital by a doctor licensed to practice medicine. Benefits will also be provided for:

(1) Surgical services performed by a doctor of surgical chiropody (D.S.C.) acting within the scope of his license, which are described in the Schedule of Surgical Operations – Chiropody (made a part hereof by reference).

(2) Obstetrical services, including necessary prenatal and postnatal care, for pregnancies of female Employees and wives of Employees.

(3) Non-operative procedures performed in lieu of surgery by a doctor licensed to practice medicine which are described in the "Schedule of Miscellaneous Specific Therapeutic Procedures" (made a part hereof by reference).

(4) The administration of anesthetics, except local infiltration anesthetic, other than in a hospital in connection with

surgical or obstetrical services for which benefits are provided under the Program, when administered and billed by a doctor licensed to practice medicine (other than the operating surgeon or his assistant) who is not an employee of, nor compensated by, a hospital, laboratory, or other institution.

(5) Preparation of casts, made of plaster and other synthetic molded materials, required for medical treatment.

(6) Facility charge of a free standing surgical center in connection with a surgical procedure for which benefits are payable under this paragraph (a).

(7) Medical services and supplies when rendered by a doctor and are needed and consistent with the treatment for which care is being rendered for the following:

(i) Charges made by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) for emergency care rendered in a medical facility or physician's office following an accident.

(ii) Special bandages, crutches, braces, trusses, and splints, including services related to the initial fitting and adjustment of these items, when provided and charged by a hospital or other qualified personnel.

When the surgical services are performed on an in-patient of a hospital,

benefits will also be provided for the services of a doctor licensed to practice medicine who actively assists the operating surgeon in the performance of such surgical services when the type and complexity of the surgical service and the condition of the patient requires such assistance and when the hospital does not have an approved intern or resident training program or a house officer or does not have surgical assistance routinely available as a service provided by a hospital intern, resident, or house officer.

(8) Organ transplants when coordinated by the Network Administrator in an approved network transplant facility. Organ donors will also be covered in the network when the recipient is covered for hospital, surgical and medical benefits under this Exhibit A-1. Reasonable travel and lodging expenses for the patient, the patient's spouse or family member and an eligible organ donor will be paid up to a total of $10,000.

If employees and eligible dependents do not have organ transplants coordinated by the Network Administrator in a network facility, benefits under this Exhibit A-1 will be limited to only eligible charges, up to the amount that would have been paid if the transplant was done in a network facility. However, travel and

lodging expenses will not be included or paid.

(b) Second Surgical Opinions

Benefits will be provided for examinations for second surgical opinions in connection with a non-emergency surgical procedure. A non-emergency surgical procedure is defined as a procedure which may be scheduled at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

4. Reasonable and Customary Fee

Whenever benefits are provided in accordance with the foregoing Paragraph 3 of this Exhibit A-1, the amount of any such benefit will be determined on the basis of a responsible and customary fee for the services performed.

This means that, subject to any maximums specified in this Exhibit A-1, and other limitations of the Program, the Program will pay the charges of the doctor for the service performed, but not more than the reasonable and customary fee. The carrier will determine the reasonable and customary charge for the procedure and normally payment will be made directly to the doctor.

In determining the reasonable and customary fee, the following will be considered:

(a) The usual fee which the individual doctor most frequently charges the majority of his patients for a like service or procedure.

(b) The prevailing range of fees in an area charged by most doctors of similar training and experience for a like service or procedure. An area may be a municipality or, in the case of a large city, a subdivision thereof, or such greater area as is required to determine prevailing charges.

(c) Unusual circumstances or medical complications requiring additional time, skill or experience.

If a charge appears to be excessive, the carrier will take appropriate steps to obtain information and medical advice which might support the additional amount. It will accept the recommendations of independent professional sources such as Medical Society Review Committees. If the charge still appears to be excessive, it will take every reasonable action to resolve it without residual payment by the Employee, including assistance with respect to the defense of a legal proceeding. If an Employee (dependent) contracts with a doctor for a charge in excess of a reasonable amount, as determined by the carrier, the Program will not pay such excess.

An Employee who is required to appear and defend against a civil action instituted by a doctor for collection of a fee in excess of "reasonable and customary" fee shall be compensated for time lost from his regular scheduled shift. The rate of pay shall be "actual hourly earnings" as determined in accordance with Article VIII, Section 10(b) of the Basic Agreement.

5. Hospital-Medical Benefits for Employees and Dependents

Benefits will be paid for visits during a hospital confinement by a doctor licensed to practice medicine.

The amount of the benefit will be the fee charged by the doctor up to $70.00 for the first day of confinement that he makes one or more calls and $35.00 for each day that he makes one or more calls during the next 729 days of the same confinement. Benefits will not be payable for calls made at time of an operation, or obstetrical procedure or for calls made after an operation or obstetrical procedure if due to the condition which caused the operation or obstetrical procedure unless such calls were during a subsequent confinement separated by a non-confinement period of at least 7 days.

There is no limit to the number of periods of hospital-medical services for which benefits will be paid if the confinements are due to different causes, or if they are separated by complete recovery or by a period of 90 days, or, in the case of an Employee, if they are separated by a return to full-time work.

Benefits shall also be provided for the first routine hospital visit to a new-born child by a physician. The amount of the benefit shall not exceed $70.00.

6. Post-Hospital Benefits

(a) Convalescent Nursing Unit Care

(1) Charges made by an approved Convalescent Nursing Unit for room and board will be paid providing the Employee or his dependent has been confined in a hospital for at least 3 days and then admitted to such Convalescent Nursing Unit within 21 days following the hospital confinement upon the written recommendation of the attending physician certifying that the patient's condition would require hospital confinement if Convalescent Nursing Unit care were not available. Re-admission upon the attending physician's recertification to such Convalescent Nursing Unit within 14 days following discharge will be considered a continuation of the same confinement for purposes of this Paragraph 6(a).

(2) The maximum daily allowance for all such board and room charges will be the charge actually made by the Convalescent Nursing Unit but not more than 50% of the daily rate which, immediately prior to such transfer, was being charged for semi-private room and board by the hospital from which the patient was transferred. Such allowance shall be paid only so long as the attending physician certifies that hospital confinement would continue to be necessary if Convalescent

Nursing Unit care were not available The maximum period for which an allowance will be paid for charges arising from any one cause will be the lesser of (a) 100 days and (b) the excess of the maximum number of days for which Hospital Expense Benefits are available under the applicable provisions of this Exhibit A-1 over the number of days of hospital confinement for such cause for which Hospital Expense Benefits were payable.

(3) The term "Convalescent Nursing Unit" means a licensed institution approved by the Social Security Administration pursuant to Title XVIII (Health Insurance for the Aged) of the Social Security Act, as amended in 1965. The term "Convalescent Nursing Unit" shall also include those institutions listed as "Extended Care Facilities" in the list titled "Accredited Extended Care Facilities" issued by the Joint Commission on Accreditation of Hospitals as it may be amended from time to time. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, or as a facility for the aged or for the care of drug addicts or alcoholics.

(b) Visiting Nurse Service

Charges will be paid when an Employee or dependent receives medical treatment in his

home by a Registered Nurse (RN) or a Licensed Physical Therapist employed regularly by any approved Visiting Nurse Service when medically necessary and ordered in writing by the attending physician.

The allowance for Visiting Nurse Service charges shall be the standard charge of the Visiting Nurse Service but shall not exceed $45.00 for each day such services are rendered to a maximum of 100 days for any one cause during any calendar year. Such allowance shall be paid only so long as the attending physician certifies such medical treatment to be necessary.

The term "Visiting Nurse Service", as used herein, means an organization or agency which meets all of the following requirements:

(1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services.

(2) Its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse to govern the services provided.

(3) It provides for full-time supervision of such services by one registered nurse and has an administrator, and

(4) It maintains a complete medical record on each patient.

7. Prescription Drug Benefits

(a) General

Prescription drug payments will be made if an Employee or Dependent, as a result of an accident or sickness, incurs expenses for covered prescription drugs dispensed by any person or organization legally licensed to dispense drugs, upon the order of a physician licensed to practice medicine.

(b) Benefits

(1) Benefits will be provided through participating providers who have agreed to accept an assignment of the benefit claim hereunder by the Employee to the provider plus a co-payment by the Employee or Dependent of $5.00 for generic medication of $10.00 for name brand drugs as full payment for the covered prescription drug. The co-payment amount herein is to be paid by the Employee or his Dependent and is applicable to each separate prescription order and to each refill thereof.

(2) Maintenance drug requirements may be filled through the Mail Order Prescription Service established by the Company in which case the above co-payment is waived.

(3) Benefits will also be provided through a local pharmacy or pharmacies who have agreed to enter into a preferred provider agreement, as approved by the Company, and referred to as a Super PPO. When prescription drug requirements are filled through the Super PPO, a $2.00 co-payment is required to be paid by the Employee or his dependent for generic medication and a $4.00 co-payment is required to be paid by the Employee or his dependent for name brand drugs. The co-payment herein is applicable to each separate prescription order and to each refill thereof.

(4) If a covered prescription drug is dispensed by a non-participating provider, the amount of the benefit for each separate prescription order and each refill thereof will be:

(i) The dispensing fee for the covered prescription drug which the individual provider most frequently charges his customers for dispensing similar drugs, plus

(ii) the actual cost of the covered prescription drug to the provider, plus

(iii) any applicable state sales tax for the covered prescription drug, less

(iv) $5.00 for generic medication or $10.00 for name brand drugs.

(5) Notwithstanding the above benefit provisions, if the physician authorizes a generic medication to be dispensed and the patient insists on a name brand drug, the reimbursement shall be limited to the amount payable if the generic drug had been dispensed.

(c) Covered Prescription Drugs

The prescription drugs covered by this paragraph are:

(1) Injectable insulin, or any Prescription Legend Drug for which a prescription is required;

(2) A compound medication of which at least one ingredient is a Prescription Drug; and

(3) Any other drug which under the applicable state law may be dispensed only upon the prescription of a physician;

Provided that a prescription drug shall not be covered under this Paragraph if (i) the cost thereof is included in the cost of other services or supplies provided to or prescribed for the Employee or his dependent or (ii) such drug is consumed at the time and place the prescription is ordered; except, however, a drug dispensed by a licensed pharmacy doing business with the public will be covered.

"Prescription Legend Drug" means for the purpose of this Paragraph, any medical substance, the label of which, under the Federal Food, Drug, and Cosmetic Act, as from time to time amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription".

(d) Exclusions

(1) No benefit shall be payable to an Employee or his Dependent if he is entitled to receive reimbursement under any Workers' Compensation Laws or is entitled to benefits from any municipal, state, federal or other governmental program of any sort.

(2) No benefit shall be payable for any medications or device which is to be used for contraceptive purposes, or for any therapeutic device or appliance (e.g., hypodermic needles, syringes, support garments and other non-medical substances).

(3) No benefit shall be payable for the administration of any medication.

(4) When a prescription drug is dispensed through a participating provider, no benefit shall be payable for any medication for which the customary and usual charge is less than $5.00 for generic medication or $10.00 for name brand drugs.

When a prescription drug is dispensed through a Super PPO, no benefit shall be payable for any medication for which the customary and usual charge is less than $2.00 for generic medication or $4.00 for name brand drugs.

(5) No benefit shall be payable for more than a 100-day supply of any medication, for any refill in excess of the number specified by the physician, or for any refill dispensed after one year from the physician's order.

(6) No benefit shall be payable for any drug defined in paragraph (c) above, the reimbursement for which is considered taxable income by the Internal Revenue Service.

8. Benefits for Chiropractic Services

The Employer will provide the following benefits for chiropractic services for eligible Employees and their dependents as follows:

(a) Benefits will be paid for charges for chiropractic services of manipulations or adjustments for the treatment of non-occupational neuromusculoskeletal conditions which are performed by and during a visit to a duly licensed Chiropractor (D.C.) or Doctor of Osteopathy (D.O.) practicing within the scope of their license, subject to a maximum of 30 visits per calendar year per individual. The allowance per visit will be determined on the

basis of a reasonable and customary fee for the services performed.

(b) Benefits will also be paid for charges incurred for X-rays made during any such visit when necessary for the diagnosis and analysis of such neuromusculoskeletal conditions. The amount of the benefit will be the reasonable and customary fee for such X-rays by Chiropractors (D.C.) or Doctors of Osteopathy (D.O.). The maximum allowance for all such X-rays arising out of the same condition will be $100 for each Employee or dependent of an Employee during a calendar year.

9. Eligibility for Benefits under Exhibit A-1

(a) Active Employees on the Effective Date will be covered by the provisions of this Exhibit A-1 on that date. Employees not actively at work on the Effective Date, will be covered by the provisions of this Exhibit A-1 immediately upon their return to work, but, until such return to work, will have such coverage for hospital expense, surgical, hospital-medical and prescription drug benefits, if any, and for such period of time as is provided for them in the plan in effect prior to the Effective Date.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

(b) Employees hired after the Effective Date. will become covered by the provisions of this Exhibit A-1 on the 31st day of employment.

(c) Coverage for an Employee's dependents will become effective on the same date as the Employee's coverage except that if a dependent, other than a new-born baby or a child placed for adoption with the Employee, of an Employee hired after the Effective Date, is confined in a hospital when the coverage for that dependent would otherwise become effective, the coverage will become effective upon final discharge from the hospital.

(d) An Employee's dependents are:

(i) The spouse, and unmarried children of the Employee under 19 years of age including a child placed with the Employee for adoption and the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Eligibility as a dependent for a child placed with the Employee for adoption terminates upon the termination of the legal obligation of the Employee for total or partial support of the child.

(ii) Unmarried children of the Employee who are eligible as dependents may continue to be deemed eligible dependents of the Employee beyond age 19 provided such children upon attainment of age 19

are both dependent upon the Employee, and either:

(a) mentally or physically incapable of self-support, or

(b) a full-time student.

Extended eligibility as a dependent beyond age 19 will terminate when the Employee's child is:

(a) no longer mentally or physically incapable of self-support as a result of the disability which gave rise to the original extension of coverage. In the case of a child who is no longer mentally or physically incapable of self-support, the child may again be deemed to be an eligible dependent as mentally or physically incapable of self-support if the child otherwise meets the requirements of this sub-paragraph (d) and, within 24 months following the date the child ceased to be eligible for coverage, requalifies as a child mentally or physically incapable of self-support as a result of the disability which gave rise to the original extensions of coverage, or

(b) no longer a full-time student. In the case of a full-time student, the child who attains age 19 or ceases to be a full-time student may again be deemed to be an eligible dependent

as a full-time student if the child otherwise meets the requirements of this sub-paragraph (d) and within 24 months following the date the child ceased to be a full-time student, requalifies as a full-time student.

Eligibility will also be extended to a child who was covered as a full-time student following the attainment of age 19 and while covered as a full-time student becomes disabled as herein defined. However, such eligibility will not be extended beyond the attainment of age 27.

(iii) The donor of an organ for transplant, when the recipient is covered for hospital, surgical, and medical benefits under this Exhibit A-1, shall also be covered for such benefits as though he were a covered dependent child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor.

The word "child" in addition to the Employee's own children includes such stepchildren, foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, placement for adoption, or marriage, such dependent shall not become eligible until three months have elapsed from the date such

child was added to the Employee's enrollment record.

10. Layoff

(a) In the event of layoff, coverage under this Exhibit A-1 will be continued without cost to the Employee for 90 days following layoff.

(b) Thereafter, coverage will be continued without cost to the Employee for a period during which he is laid off for one of the reasons set forth in Article I, Section 4(a) of the Goodyear Supplemental Unemployment Benefits Plan maintained by the parties hereto under Agreement as amended on July 20, 1994 and with respect to which he receives no earnings for work performed for the Employer; but the maximum period of such continued coverage shall be determined in accordance with the following table:

Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him	**Maximum Number of Months for which Hospital, Surgical, Medical, Dental, Prescription Drug and Major Medical Coverages Will Be Continued Without Cost to Employee**
6-19	1
20-23	2
24-27	3
28-31	4

32-35	5
36-39	6
40-43	7
44-47	8
48-52	9

(i) In applying the above table, the "Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him" shall be determined by dividing the number of the Employee's Credit Units under the Supplemental Unemployment Benefits Plan by the number of Credit Units to be cancelled for one SUB Benefit in accordance with the Credit Unit Cancellation table contained in Article III, Section 4 of such Supplemental Unemployment Benefits Plan, based on the Employee's seniority and the Trust Fund Position in effect as of the last day worked prior to layoff. The "Maximum Number of Months for Which Hospital, Surgical, Medical, Dental, Prescription Drug and Major Medical Coverages Will Be Continued Without Cost to Employee" shall commence with the 91st day of layoff.

(ii) With respect to any period of continuous layoff, changes in an Employee's Credit Units, Seniority or Trust Fund Position subsequent to the date layoff begins shall not change the number of months of continued coverage for which such Employee is eligible.

(iii) In the event that the aforesaid Goodyear Supplemental Unemployment Benefits Plan shall be terminated in accordance with its terms prior to the termination of this Agreement, Subparagraph (b) of this Paragraph 10 shall thereupon cease to have any force or effect.

(iv) The foregoing provisions of this Subparagraph (b) shall be subject to the Employer obtaining and retaining from the Commissioner of Internal Revenue and from the United States Department of Labor the rulings referred to in the Agreement between the parties of July 20, 1994 relating to Supplemental Unemployment Benefits, and shall be effective with respect to layoffs commencing on or after the first day of the month following the month in which such rulings are received by the Employer. Pending receipt of said rulings, the foregoing provisions of this Subparagraph (b) will nevertheless be made operative as to any Employee for a period up to 90 days.

(c) The maximum period of coverage under this Paragraph 10 shall be 24 consecutive months following the month in which the Employee was laid off. For any month in this period not covered by Employer-furnished coverage, the Employee may continue the coverage by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage.

(d) An Employee on layoff may not continue coverage as provided in (c) above while covered by any other employer-furnished non-contributory hospital, medical and surgical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the 24-month maximum period. In order to remain eligible for continued coverage as provided in (c) above, the Employee must maintain such coverage continuously except as provided above in this Subparagraph (d).

(e) Employees re-employed with credit for prior service will have an immediate reinstatement of coverage.

(f) An Employee on layoff eligible for coverage under this Paragraph 10 upon acceptance of any benefits payable under Article XIII of the 1950 Pension Plan shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this Paragraph 10.

11. Leave of Absence, Etc.

(a) During authorized leave of absence, (other than leaves for which coverage is provided in sub-paragraphs (b), (c) and (d) below), coverage under this Exhibit A-1 will be continued for a period not to exceed 90 days. Employees on leave of absence extending beyond such 90-day period may, by application to the Employer during such period and advance

payment of current group rate premium, continue such coverage during the period of such leave of absence. An Employee who leaves the employ of the Employer as the result of being elected or appointed to public office or to an office in a Local Union cooperative enterprise serving Company employees may, by application to the Employer prior to leaving his employment with the Employer and upon advance payment of the current group rate premium, continue such coverage during the period of his service in such office.

(b) During an authorized leave of absence for active duty in Armed Forces for a period of less than six months, an Employee (and his eligible dependents) shall continue to be eligible for the benefits provided in this Exhibit A-1 to the extent that such benefits are not provided by the Military Service or the Federal or State Government.

(c) During an authorized leave of absence for pregnancy, Employees (and their eligible dependents) will continue to be covered subject to the provisions of this Exhibit A-1, during the period in which they accumulate seniority.

(d) Notwithstanding the foregoing, coverage shall be continued without cost to the Employee during the period of an Employee's authorized leave of absence granted by his Employer for service with a local Union in an official or representative capacity or while

representing such local Union in a State, County, or City council of AFL-CIO-CLC.

12. Injury or Sickness

Employees off work due to injury or sickness will continue to be covered subject to the provisions of this Exhibit A-1, during the period in which they accumulate seniority.

13. Termination of Coverage Under Exhibit A-1

Except as described in Paragraphs 10, 11, and 12 immediately above, all coverage will terminate when active employment with the Employer terminates except as follows:

(a) The hospital, surgical, hospital-medical and prescription drug benefits for an Employee or dependent will be extended for three months following termination of coverage to cover a hospital confinement, an operation or obstetrical procedure resulting from a continuous total disability which began while the coverage was in force.

(b) Coverage will be extended for six months for the spouse and dependent children of an Employee who dies while on the payroll of the Employer, while on sick leave (and accumulating seniority), while on layoff with Exhibit A-1 coverage provided continuously under Paragraph 10 of this Exhibit A-1, during authorized leave of absence for a period not to exceed 90 days, or while on authorized leave of absence for service with a Local Union in an official or representative capacity.

The surviving spouse of a deceased Employee who is not eligible for continued coverage under Paragraph 15 (b) of this Exhibit A-1 may elect, within such six months, to extend such coverage for up to an additional 18 months by payment in advance of the current group rate premium. Such spouse may make arrangements for the premium to be paid (i) in a lump sum amount equal to 14 monthly payments which may be deducted from any benefits the spouse is entitled to receive under Section A, Life Insurance or (ii) in quarterly installments paid directly to the Company.

(c) Coverage for an unmarried full-time student will be extended for 90 days following termination of status as full-time student provided no other group medical coverage of any kind is in effect on such student.

(d) Where practicable the Employer will arrange with an insurance company for issuance of individual policies of medical expense benefits without medical examination when elected by an individual whose coverage terminates as provided in Paragraphs 10, 11, 12 and this Paragraph 13 or with respect to a child who no longer meets the eligibility requirements of this Exhibit A-1. Issuance of such an individual policy will be subject to the following:

(i) the Employee has been covered for 3 or more months under Exhibit A-1, and

(ii) a written application and payment of the first 3 months' premium is made within 31 days following termination of coverage under Exhibit A-1, and

(iii) the individual policy will be one of the policies issued by the insurance company for conversion purposes and subject to the terms and conditions of said policy.

14. Employees Retired on Pension

Employees who retire with 10 or more years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan), shall continue to receive the benefits described in this Exhibit A-1; provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

Employees who retire with less than 10 years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan) may elect to receive the benefits described in this Exhibit A-1 by

payment in advance of the Group Rate as estimated by the Company annually in advance.

Employees hired after April 23, 1988 and who retire after completion of at least 20 years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan), shall continue to receive the benefits described in this Exhibit A-1.

Employees hired after April 23, 1988 and who retire after completion of at least 10 years of continuous service but less than 20 years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan), shall continue to receive benefit amounts equal to 50% of the benefits described in this Exhibit A-1; provided, however, that such retired employee may elect to continue the full benefits of this Exhibit A-1 by payment in advance of 50% of the Group Rate as estimated by the Company annually in advance.

Notwithstanding the above, Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1950 Pension Plan whose full years of attained age and full years of attained continuous service at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of the benefits described in

this Exhibit A-1. An Employee earns one point for each year of attained age and one point for each year of attained continuous service. Total points are derived by adding together the attained age and attained continuous service points. Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the benefits described in this Exhibit A-1. Failure to pay the required medical contribution will result in cancellation of coverage.

An Employee who retires with thirty (30) or more years of service at any age will receive 95 points at retirement.

An Employee who retires with a disability pension with ten (10) or more years of service will receive an additional 30 points at retirement.

An Employee who does not preferentially hire and subsequently retires as a result of a plant closure will receive an additional 15 points at retirement.

An Employee who, on January 1, 1996 is:

(a) Age 50 or older and has 10 or more years of continuous service but less than 30; or

(b) Any age and has 20 or more years of service but less than 30;

will receive an additional 15 points which will be added to the Employee's point total at the time of their retirement.

As an alternative to the above, an Employee required to make the described health care contribution may elect, at the time of retirement, a catastrophic medical plan option based on the benefits described in Exhibit B-1 of the Pension, Insurance and Service Award Agreement dated April 29, 1994. The deductible under this option shall be $1,000 per covered individual per year, $2,000 per family per year, 80% Company co-payment, 20% retiree co-payment and a retiree co-payment maximum (after the deductible is satisfied) of $1,000 per covered individual, or $1,500 per family per year. There is no health care contribution required for this option.

A retired employee required to make a health care contribution as described above shall be afforded the opportunity to change his medical plan option election in the event there is a change in the amount of the retiree medical contribution required or there is a change in the plan design.

15. Survivor Benefits

(a) The surviving spouse of (i) a deceased Employee who retires on or after the Effective Date, and was eligible for and receiving a monthly pension (other than a deferred vested pension or any benefit under Articles XI, XII or XIII of the 1950 Pension Plan), and (ii) a former Employee whose employment was terminated on or after the Effective Date, at

or after attainment of age 60 and who dies after he has commenced to receive a deferred vested pension, shall be entitled to continue to receive the benefits of this Exhibit A-1 until death or remarriage under the exact same conditions and amounts that such surviving spouse was entitled to such benefits as a dependent immediately prior to the death of such deceased former Employee, provided such surviving spouse was either an eligible spouse at the time of the Employee's retirement or had been legally married to the Employee for at least 12 consecutive months preceding his death.

Also, the surviving dependent of an Employee who is retired by the Employer and receiving a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan) on or after the Effective Date, provided such dependent as of the date of the death of such retired Employee was covered by these benefits as an eligible dependent, shall continue to be eligible to receive the exact same benefits and under the same conditions so long as the dependent continues to qualify as such, provided such surviving dependent was either an eligible dependent at the time of the Employee's retirement or was also a dependent of a surviving spouse who had been legally married to the Employee for at least 12 consecutive months preceding his death.

(b) The benefits provided under this Exhibit A-1 shall continue for the spouse and dependents

of an Employee who had (i) attained age 55 or more and had 10 or more years of continuous service or (ii) 20 or more years of continuous service, and who dies and at the date of death was eligible for said benefits, was on the payroll of the Employer, was on sick leave (and accumulating seniority), was on layoff with Exhibit A-1 coverage provided continuously under Paragraph 10 of this Exhibit A-1, was on authorized leave of absence for period not to exceed 90 days, or was on authorized leave of absence for service with a Local Union in an official or representative capacity. Such coverage shall terminate when spouse remarries or dies; provided that such coverage for each such dependent shall continue after the death of the spouse (if the spouse has not remarried) so long as the dependent continues to qualify as such (but for being dependent on the Employee) under (i) or (ii) of Paragraph 9(d) of this Exhibit A-1.

16. Special Medicare Benefit

(a) Eligibility for Benefit

An Employee, Pensioner or eligible Surviving Spouse, and their eligible dependents, who are eligible for benefits under this Exhibit A-1 will be eligible for a Special Medicare Benefit upon (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, when first eligible to enroll in Part B of Medicare with Medicare as primary coverage provided the individual

enrolls and continues to be enrolled in Part B of Medicare.

(b) Amount of Benefit

The amount of the Special Medicare Benefit will be equal to the lesser of the standard monthly premium for Part B of Medicare or $48.00 that is paid by persons who enroll when first eligible for primary Medicare coverage but shall not include any additional premiums such as those charged for delinquent enrollment.

(c) Payment of Benefit

The Special Medicare Benefit will be paid to the Employee, Pensioner or eligible Surviving Spouse. Payment of the Special Medicare Benefit will commence on the first day of the month following (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, the first day of the month following the month for which such individual is eligible to enroll in Part B of Medicare with Medicare as primary coverage, provided the individual enrolls in Part B of Medicare.

Payment of the Special Medicare Benefit shall continue so long as the Employee, Pensioner or eligible Surviving Spouse and the eligible dependents continue to be covered for benefits under this Exhibit A-1 and continue to be enrolled for coverage under Part B of Medicare.

The Special Medicare Benefit will not be paid for any eligible dependent who is also eligible for this Special Medicare Benefit as an Employee, Pensioner or Surviving Spouse or when such dependent is reimbursed by another employer for the Medicare Part B premium. When a dependent child is covered by this Paragraph under more than one Employee or Pensioner, the Special Medicare Benefit will be paid only to the male Employee or Pensioner.

17. Miscellaneous Provisions

(a) The Employer will use all reasonable efforts to cause the hospital to furnish patients entitled to benefits under this Exhibit A-1 with a duplicate itemized statement of the charges made by it.

(b) The term "hospital" means an institution that is an acute care medical facility and is equipped to handle all regular medical and surgical cases including U.S. Veterans' hospitals for non-military service related medical conditions in which the veteran is legally required to pay for the medical services provided but shall not include those institutions whose main facilities are designed for the treatment of injuries or sickness by methods other than medicine or surgery. It must have a resident staff of registered graduate nurses, a resident doctor, facilities for the care of bed patients on an in-patient basis, in-house facilities for surgery, routine laboratory tests and x-rays. It must operate on a 24-hour

basis and be licensed, as a hospital, by the state in which it operates providing it is so required by such state. In no event, however, shall such term include an institution which is principally a rest home, nursing home, or a home for the aged or is primarily engaged in rehabilitation, in-patient psychiatric care or the care and treatment of drug addicts or alcoholics.

(c) From time to time the Company may designate specific medical care facilities or other providers of medical care, services, or supplies as "approved" under Exhibit A-1 even though such facilities or providers do not meet the strict definitions of this Exhibit A-1. Charges by such "approved" facilities or providers for care, services or supplies which would otherwise be covered under this Exhibit A-1 will be paid in accordance with the terms and conditions of Exhibit A-1.

(d) Any payment for any benefit under this Exhibit A-1 which is payable to a hospital shall be paid directly to the hospital entitled thereto. If an Employee pays directly to the hospital any of the charges upon which the claim is based and furnishes the Employer or insurance carrier satisfactory evidence of such payment, such Employee shall be paid the benefit payment in accordance with the provisions hereof.

(e) Written proof of charges upon which a claim may be based for benefits under this Exhibit A-1 must be furnished within 12 months

after the end of the calendar year in which the charges were incurred. Failure to furnish proof within the time stated will not invalidate nor reduce any claim if it can be shown that the delay was unavoidable and that such proof was furnished as soon as was reasonably possible.

(f) In enrolling an individual as a Employee or eligible dependent or in determining or making any payments for benefits of an individual as an Employee or eligible dependent, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

(g) Any payment for any benefit with respect to an Employee or eligible dependent under this Exhibit A-1 will be made in accordance with any assignment of rights made by or on behalf of such Employee or dependent as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912 (a) (1) (A) of the Social Security Act as in effect on August 10, 1993.

(h) To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which this Exhibit A-1 has a legal liability to make payment for items or services constituting such assistance, payment for benefits under this Exhibit A-1

will be made in accordance with any State law which provides that the State has acquired the rights with respect to an Employee, spouse of an Employee, or dependent of an Employee to such payment for such items or services.

18. Alternative (Group Practice) Plans

(a) The Company will make arrangements to afford individual Employees the option to subscribe to Group Practice Plans when they become available in their area, if such plans are approved by the Company, in lieu of all the coverages provided in Exhibit A-1, subject to the limitation on Company contributions contained in Subparagraph (b) below. Subsequent opportunities to exercise or revoke the exercise of such option shall be provided as may be mutually agreed upon by the Company and the Local Union but not more frequently than once in any 12-month period.

(b) On behalf of each Employee subscribing to a Group Practice Plan under Subparagraph (a) above, the Company will make monthly contributions to such plan towards the cost of such coverage; provided, however, that the Company's contributions shall not exceed the average cost of providing benefits under the Exhibit A-1 for Employees and dependents as estimated annually in advance by the Company for all locations covered by the Basic Agreement.

19. Coordination of Benefits Under Exhibit A-1

(a) If an Employee, the spouse of an Employee, or the dependent of an Employee (including the surviving spouse or a surviving dependent of a deceased Employee) is covered or is eligible to be covered except in those cases where contributions for coverage are required (except as provided in sub-paragraph (g) below), by another employer-sponsored group hospital, surgical, medical, death or prescription drug program (except a Group Practice Plan or Health Maintenance Organization Plan), the payment allowable under Exhibit A-1 will be coordinated with the payments payable under such other group program.

For purposes of employer-sponsored flexible benefit programs, an individual will be considered "eligible to be covered" as mentioned above, whenever hospital-surgical-medical coverages were available and such coverage was not elected.

(b) When such other group program has been determined to be primary (as defined in sub-paragraph (c) below), the payment allowable under Exhibit A-1 for any service or prescription drug covered by Exhibit A-1 will be equal to the smaller of:

(i) 100% of the charge for such service or prescription drug (but not more than the reasonable and customary charge for services covered under Paragraph 3 of Exhibit A-1) less the amount payable by

such primary group program for such service or prescription drug, and

(ii) the amount which would have been payable for the service or prescription drug under Exhibit A-1 had there been no such other group program.

(c) Such other group program will be considered as primary:

(i) when the spouse or a dependant of an Employee (including a surviving spouse or a surviving dependent of a deceased Employee) is covered by such other group program, or

(ii) when an Employee, whose credited service is less with the Employer than with the employer sponsoring such other group program, is covered by such other group program as an employee, or

(iii) in any case, when such other group program does not contain a non-duplication or coordination of benefits provision.

(d) In those cases where both husband and wife are covered as Employees under this Program, either Employee will be considered eligible for benefits as a dependent of the spouse, but the total payment under the Program shall not exceed the charge for each covered expense.

(e) In those cases where both husband and wife are employed, the program of the parent whose birthdate (month and day only) falls

earlier in the calendar year will be considered as primary with respect to that parent and dependent children of the husband and wife and the parent whose birthdate (month and day only) falls later in the calendar year will be considered as primary for that parent and secondary with respect to the dependent children of the husband and wife. If the husband and wife have the same birthdate (month and day only), the program covering the parent longer is primary with respect to the dependent children and the program covering the other parent for the shorter time is secondary with respect to the dependent children.

When the program of the Employee's spouse does not determine primary coverage for dependent children based on birthdate, the program covering the husband as an Employee will be considered as primary with respect to the husband and his dependent children. The program covering the wife as an Employee will be considered as primary with respect to the wife.

In the case when parents are separated or divorced and the parent with custody of dependent children has not remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the parent without custody.

In the case when parents are divorced and the parent with custody of dependent children has remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the stepparent. The dependent coverage of the stepparent will be primary to the dependent coverage of the parent without custody.

In the event there is a court decree which would otherwise establish financial responsibility for the medical care expenses with respect to dependent children, the dependent coverage of the parent with financial responsibility will be primary.

The Company shall establish reasonable procedures to determine the status of medical child support orders and to administer the payment of benefits under medical child support orders which are deemed to be qualified orders. Such procedures shall be in writing and shall comply with the provisions of Section 609 of the Employee Retirement Income Security Act of 1974, as amended.

(f) When the patient is an Employee covered under this Program, this Program will be the primary program regardless of whether or not the other group program contains a coordination of benefits provision, except in the case of duplicate employment when the Employee has more credited service with the employer sponsoring such other group

program and except as provided in subparagraph (g) of this paragraph.

(g) Medicare and any other Federal, State or government-sponsored hospital, surgical, medical, dental or prescription drug program (including payments made under any "No Fault" liability insurance program) will be considered as though such government-sponsored program were another employer-sponsored group program and will be considered as primary, except as otherwise prohibited by law.

For purposes of this paragraph, an Employee, Pensioner or eligible Surviving Spouse, and their eligible dependents, who are eligible to receive the Special Medicare Benefit provided under this Program shall be considered covered under Part B of Medicare whether or not each person has actually enrolled for coverage under Part B of Medicare. An employee who works beyond age 65 shall have this Program as primary and Medicare as secondary during the period the Employee continues actively working after age 65.

When any medical service or supply is both eligible for payment under Exhibit A-1 and under Part B of Medicare, the amount of benefit payable hereunder will be equal to the portion of the charge for such services not covered by said Part B.

(h) In the event, an Employee (including the surviving spouse or a surviving dependent of a deceased Employee) is covered by such

other group program, the benefit for hospital expense, allowable under Exhibit A-1 will include private room charges when semi-private or ward accommodations are not available or when private room accommodations are certified as medically necessary by the attending physician.

(i) When an Employee, the spouse of an Employee, or the dependent of an Employee (including the surviving spouse or a surviving dependent of a deceased Employee) elects coverage under a Group Practice Plan or a Health Maintenance Organization Plan, benefits otherwise payable under Exhibit A-1 except as described below will not be paid and Coordination of Benefits provisions described in sub-paragraphs (a) through (h) of this Paragraph 19 will not be applicable.

If, however, a spouse of an Employee (including the surviving spouse of a deceased Employee) is provided employer-sponsored coverage under a Group Practice Plan or a Health Maintenance Organization Plan as the only available medical plan, benefits otherwise payable under this Program will be paid and Coordination of Benefits provisions described herein will be applicable.

(j) Notwithstanding any provisions in the above paragraphs to the contrary, when an Employee and spouse are both employed by the Company and eligible for medical benefits, each individual must elect medical coverage in his or her own right providing there is

such coverage available to one of the Employees on a non-contributory basis consistent with Paragraphs (a) through (g) above.

20. Listing of Dependents

Each Employee shall furnish a list of his eligible dependents on an enrollment form supplied by the Employer for such purpose. This form must be kept up to date at all times.

21. Definition of "Physician", etc

The term "physician", or "doctor", or "doctor licensed to practice medicine", or "doctor licensed to practice dental surgery" as used in this Exhibit A-1 means only Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) or a Doctor of Dental Surgery (D.D.S.), except that with respect to surgical operations coming within the scope of the "Schedule of Surgical Operations—Chiropody" the term also means Doctor of Surgical Chiropody (D.S.C.) (Podiatrist) and with respect to chiropractic treatments for neuromusculoskeletal conditions coming within the scope of his license, the term also means a Chiropractor.

For the purposes of subparagraph 2 (a) (ii) of Exhibit A-1 the term "doctor licensed to practice medicine" means also a Doctor of Surgical Chiropody (D.S.C.) (Podiatrist) when the doctor is acting within the scope of his license.

22. Insurance Contracts

The Employer may, alone, or in conjunction with other corporations subsidiary to or affiliated with

the Company, enter into a contract or contracts with an insurance company or insurance companies to provide the benefits described in this Exhibit A-1. No insurance company contract which may be entered into by the Employer for the purpose of providing any benefit described in this Exhibit A-1 shall alter, amend or detract from the provisions of this Agreement.

23. Grievance Procedure

If any difference shall arise between the Employer and any Employee with respect to whether or not the Employer has provided the benefits under this Exhibit A-1, and if agreement cannot be reached between the Employer and such Employee, such difference may be taken up as a grievance under the grievance procedure provided for under the Basic Agreement at the Manager of the Labor Department level. If any such grievance shall be taken before the impartial umpire in accordance with such procedure, then the impartial umpire shall have the authority only to decide the question pursuant to the provisions of this Exhibit A-1 applicable to the question, but he shall have no authority in any way to alter, add to, or subtract from any such provisions. The decision of the impartial umpire shall be binding on the Employer, such Employee, and all other interested parties. Termination of the Basic Agreement shall not invalidate the use of its grievance procedure for the purposes of this Exhibit A-1.

24. Subrogation

(a) In the event an Employee or a dependent of an Employee (including the surviving spouse or a surviving dependent of a deceased Employee) is legally entitled to recover all or a portion of the cost of a service or prescription drug covered by this Program from a third party, the Employer will, upon making payment under such Program, succeed to any rights of recovery the Employee or dependent may have or acquire (with respect to such service or prescription drug) against any person or organization except insurors of individual hospital, surgical, or medical policies issued to the Employee or dependent.

(b) Employees (including dependents, surviving spouses or surviving dependents of deceased Employees) by acceptance of such benefit payments agree to furnish such information and assistance, and execute such assignments and other instruments as the Employer may reasonably request to facilitate enforcement of the successor rights of the Employer. Employees and their dependents shall take no action prejudicing such rights of the Employer.

(c) An Employee who is required to appear and defend against a civil action involving this Subrogation provision shall be compensated for time lost from his regular scheduled shift. The rate of pay shall be "actual hourly earnings" as determined in accordance with

Article VIII, Section 10 (b) of the Basic Agreement.

25. Health Care Utilization Review

(a) The Health Care Utilization Review Program provides a wide range of services to assure that Employees and Dependents receive quality health care in an efficient, cost-effective manner. The Utilization Review Firm is responsible for the administration of all aspects of Utilization Review.

(b) Services Provided

The Utilization Review Firm shall be responsible for the administration of the following services which are all part of an integrated approach to quality, cost-effective health care for Employees and their Dependents.

(i) Hospital Admission Pre-certification as set forth in paragraph 1 (c) of this Exhibit A-1.

(ii) Concurrent Review as set forth in paragraph 1 (c) of this Exhibit A-1.

(iii) Pre-Admission Testing as set forth in paragraph 1 (c) of this Exhibit A-1.

(iv) Second Medical or Surgical Opinions may be requested whenever the need for surgery cannot be confirmed. In those cases, the Utilization Review Firm will make the arrangements, with consideration given to the convenience of the patient.

(v) Consumer Education Services wherein the Utilization Review Firm will provide a toll-free telephone service to be used by Employees and their Dependents for professional answers and general education on a wide variety of health care related issues.

(vi) Premature Birth Prevention Program which is available to identify, at an early stage, pregnancies which are "high risk" and to educate the patient during the term of the pregnancy in order to minimize or eliminate the potential for premature or low birth-weight delivery.

(vii) Large Case Management which provides specialized care for catastrophic accidents or illnesses such as:

- Major organ transplants
- Premature babies requiring neo-natal care
- Spinal cord injuries
- Strokes
- Malignancies requiring intensive care
- Psychiatric care
- Hospice care for terminal patients

Upon the recommendation of a "case manager", alternative treatment and service may be approved as a benefit under the plan even when such services

would not otherwise be eligible for benefits.

(viii) Privacy and confidentiality is guaranteed by the Utilization Review Firm. All telephone conversations are tape recorded to prevent misunderstandings and to confirm the accuracy of all conversations. The tape recorded conversation of a patient or Employee may only be released upon receipt of the patient's written authorization.

26. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 26 is provided in lieu of all other coverage under Part V Section A of the Pension, Insurance and Service Award Agreement dated July 20, 1994 and Exhibit A of this Agreement. However, upon termination of coverage under this Paragraph 26, the conversion privileges of Part V Section A, Paragraph 1 of the Pension, Insurance and Service Award Agreement dated July 20, 1994 and Exhibit A-1, Paragraph 13(d) and the termination provisions of Exhibit A-1, Paragraph 13 shall apply.

Coverage under Part V, Section A of the Pension, Insurance and Service Award Agreement dated July 20, 1994 will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of said Section A. Coverage under Exhibit A will be extended following such Plant Closure

without cost to the Employee for an additional 12 months beyond Employer-furnished coverages provided in Paragraph 10 of Exhibit A-1. However, in no event shall the coverage provided in Paragraph 10(b) of Exhibit A-1 be less than 9 months. For any month in which Employer-furnished coverage is provided under Part V, Paragraph 1 of the Pension, Insurance and Service Award Agreement dated July 20, 1994, the Employee may continue to purchase coverage under Paragraph 2 of Section A of said Agreement.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Goodyear Supplemental Unemployment Benefits Plan, coverage under Exhibit A may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 26 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 of the Pension, Insurance and Service Award Agreement dated July 20, 1994, and 36 consecutive months for coverage under Exhibit A of this Agreement following the month in which such Plant Closure occurred.

Coverage under this Paragraph 26 will not continue as provided above while the Employee is covered by any other employer-sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage

hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 26.

EXHIBIT A-2
MAJOR MEDICAL BENEFITS PROGRAM

Effective January 1, 1995 and for the duration of this Agreement thereafter, the Employer will provide the following plan of Major Medical Benefits for eligible Employees and their dependents.

A. DEFINITIONS

The following terms as used herein shall have the meanings set forth below:

1. The term "Employee major medical benefits" means benefits provided under the provisions of this major medical program pertaining to an Employee's own eligible medical expenses.

2. The term "Dependents-major medical benefits" means benefits provided under the provisions of this major medical program pertaining to eligible medical expenses of dependents.

3. The term "eligible dependent" will include only the following:

(a) The Employee's spouse, and unmarried children of the Employee under nineteen years of age including a child placed with the Employee for adoption and the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Eligibility as a dependent for a child placed with the Employee for adoption terminates upon the termination of the legal obligation of the Employee for total or partial support of the child; and

(b) Unmarried children of the Employee who are dependent upon the Employee and are over nineteen years of age, provided, as defined under the Medical Necessity Benefits Program, they are either full-time students or are mentally or physically incapable of self-support.

The word "children" in addition to the Employee's own children will include any stepchildren, foster children or other children, provided such children are unmarried, live with the Employee and depend upon the Employee for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, placement for adoption, or marriage, such child dependent shall not become eligible until three months have elapsed from the date such dependent was added to the Employee's enrollment record.

Eligibility will also be extended to a child who was covered as a full-time student following the attainment of age 19 and while covered as a full-time student becomes disabled as herein defined. However, such eligibility will not be extended beyond the attainment of age 27.

4. The term "benefit year" means the period commencing on January 1 of any calendar year and terminating at the expiration of December 31 of such calendar year.

5. The term "standard semi-private room daily rate", in the case of a hospital which does not have semi-private accommodations, means 80% of the daily charges for a hospital regular daily services made by the hospital for its lowest rate private accommodations.

6. The term "basic Employee coverage" means with respect to any Employee all the employee benefits and coverages available under the Basic Program to the class of persons to which such Employee belongs.

7. The term "basic Dependents coverage" means with respect to any eligible dependent of an Employee, all of the dependents benefits and coverages available under the Basic Program to the class of persons to which such Employee belongs.

8. The term "Basic Program" means any hospital, surgical, medical or prescription drug benefits coverage (other than Major Medical Benefits) sponsored by the Employer and any

other group insurance coverage or any prepayment coverage or other hospital, surgical or medical benefit plan or service plan or service plan of any government unit or law.

9. The term "covered individual" means an Employee or eligible dependent who is covered for major medical.

10. The term "physician" means a physician or surgeon licensed to practice medicine and perform surgery (M.D. or D.O.) and a duly licensed doctor of dental surgery (D.D.S.) or doctor of surgical chiropody (D.S.C.) (Podiatrist) practicing within the scope of his profession.

11. The term "hospital" means an institution that is an acute care medical facility and is equipped to handle all regular medical and surgical cases including U.S. Veterans' hospitals for non-military service related medical conditions in which the veteran is legally required to pay for the medical services provided but shall not include those institutions whose main facilities are designed for the treatment of injuries or sickness by methods other than medicine or surgery. It must have a resident staff of registered graduate nurses, a resident doctor, facilities for the care of bed patients on an in-patient basis, in-house facilities for surgery, routine laboratory tests and x-rays. It must operate on a 24-hour basis and be licensed, as a hospital, by the state in which it operates providing it is so required by such state. In no event, however,

shall such term include an institution which is principally a rest home, nursing home, or a home for the aged or is primarily engaged in rehabilitation, in-patient psychiatric care or the care and treatment of drug addicts or alcoholics.

12. The term "illness" means a bodily or mental disorder of any kind. However, all such disorders due to bodily injuries sustained in any one accident shall be considered one illness. Furthermore, any such disorder which is the same as, or related to, or occurs in consequence of another existing or previously existing disorder or disorders shall be considered collectively with all such existing or pre-existing disorders as one illness.

13. The term "Convalescent Nursing Unit" means a licensed institution approved by the Social Security Administration pursuant to Title XVIII (Health Insurance for the Aged) of the Social Security Act, as amended in 1965. The term "Convalescent Nursing Unit" shall also include those institutions listed as "Extended Care Facilities" in the list titled "Accredited Extended Care Facilities" issued by the Joint Commission on Accreditation of Hospitals as it may be amended from time to time. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, or as a facility for the aged or for the care of drug addicts or alcoholics.

14. The term "Clinical psychologist" means a person who provides clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who qualifies as a psychologist, in any of the following ways, in the jurisdiction (state, District of Columbia, territory or possession of the United States, or province of Canada) in which he is practicing:

(a) If statutory licensure or certification of psychologists exists in the jurisdiction, he holds a valid license or certificate of such jurisdiction as a psychologist.

(b) If statutory licensure or certification of psychologists does not exist in the jurisdiction, he holds a valid, non-statutory (professional) certification established by the jurisdiction's recognized psychological association.

(c) If neither statutory nor nonstatutory licensure or certification of psychologists exists in the jurisdiction he holds a statement of qualification by a committee established for the purpose by the jurisdiction's recognized psychological association or, in the absence of such a committee, holds a diploma in the appropriate specialty awarded by the American Board of Examiners in Professional Psychology or its Canadian equivalent.

The recognized psychological association of a jurisdiction is one which, if the jurisdiction is in the United States, is affiliated with the American Psychological Association or, if the jurisdiction is a Canadian province, is registered with that province.

15. The terms "Licensed Psychiatric Social Worker" and "Licensed Professional Counselor" mean persons who work under the direction of a psychiatrist or psychologist, hold a Master's degree in social work and have successfully completed a supervised clinical internship. The covered individual must be referred to a psychologist by a doctor licensed to practice medicine.

The person must provide clinical psychiatric services in connection with the diagnosis and treatment of mental, psychoneurotic or personality disorders, and qualifies as a licensed psychiatric social worker or licensed professional counselor, in any of the following ways, in the jurisdiction (state, District of Columbia, territory or possession of the United States, or province of Canada) in which he is practicing:

(1) If statutory licensure or certification of a psychiatric social worker or professional counselor exists in the jurisdiction as a psychiatric social worker or professional counselor.

(2) If statutory licensure or certification of a psychiatric social worker or professional

counselor does not exist in the jurisdiction, he holds a valid, non-statutory (professional) certification established by the jurisdiction's recognized psychiatric social worker or professional counselor association.

(3) If neither statutory nor non-statutory licensure or certification of a psychiatric social worker or professional counselor exists in the jurisdiction, he holds a statement of qualification by a committee established for the purpose by the jurisdiction's recognized psychiatric social worker or professional counselor association, or in the absence of such a committee, holds a diploma in the appropriate specialty awarded by the National Association or Social Workers or National Board for Certified Counselors or their Canadian Equivalent.

The recognized psychiatric social worker's or professional counselor's association of a jurisdiction is one which, if the jurisdiction is the United States, is affiliated with the National Association of Social Workers or National Board for Certified Counselors, or, if the jurisdiction is a Canadian province, is registered with that province.

16. The term "Medicare" means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added by the Social Security Amendment of 1965 or as later amended.

B. ELIGIBILITY FOR BENEFITS

Employees and eligible dependents will be covered by the provisions of the Major Medical Benefits Program described in this Exhibit A-2 provided such Employees and eligible dependents are covered under the Medical Necessity Benefits Program described in Exhibit A-1, except that if a dependent (other than a new-born baby) is confined in a hospital or Convalescent Nursing home when coverage for that dependent would otherwise become effective, coverage will not become effective until final discharge from such confinement, unless such dependent was eligible for Major Medical Benefits under the prior Agreement.

C. BENEFITS

1. General

   Benefits will be payable, in accordance with the provisions of Paragraphs 2 and 3 below, for eligible charges which are incurred in connection with a non-occupational accident or illnesses of an Employee or eligible dependent. The payment of such benefits will, however, be subject to the provisions of the section "Overall Benefit Maximums" and all other Major Medical Benefits provisions.

2. Amount

   The benefits specified below will be payable with respect to eligible charges which are incurred during a benefit year, exclusive of the charges used to satisfy the deductible applicable to the benefit year.

(a) 80% of all eligible charges incurred in connection with (i) mental illnesses or functional nervous disorders of any type or cause of any person who is a covered individual, other than charges incurred in connection with the administration of convulsive therapy and other than charges incurred during a confinement of the covered individual in a hospital for which room and board charge is made, and (ii) 50% of eligible charges for room and board in a Convalescent Nursing Home, and other services and supplies furnished by the Convalescent Nursing Home for medical care, exclusive of professional services (see additional provisions for Convalescent Nursing Home Benefits).

(b) 80% of all eligible charges, exclusive of any charges with respect to which benefits are payable under subparagraph (a) above.

3. Deductible

(a) The deductible applicable to a covered individual for each benefit year will be $175.

(b) The eligible charges used to satisfy the deductible applicable to a covered individual for a benefit year will be the first eligible charges incurred during the benefit year in an amount equal to the deductible. If all or any portion of the deductible applicable to a covered

individual has been satisfied by the application of eligible charges incurred during the last three months of a benefit year, then the deductible applicable to the covered individual for the next ensuing benefit year will be reduced to the extent of such application.

(c) If at any time during a benefit year the deductible applicable to such benefit year is individually satisfied, in accordance with sub-paragraphs (a) and (b) for any two members of a family unit, the deductible applicable to all other members of the family unit for such benefit year shall also be considered to have been satisfied.

The term "family unit" as used herein shall mean an Employee, spouse and eligible dependent children.

(d) Common Accident Provision—In the event that the Employee and one or more of his eligible dependents, or two or more eligible dependents of the Employee, sustain bodily injuries in the same accident while they are covered individuals, then for the purpose of determining benefits on account of such injuries, but for no other purpose, all eligible charges incurred in connection with such injuries of such covered individuals will, in each benefit year, be used collectively toward the satisfaction of a single deductible

applicable to all such covered individuals.

Nothing in this provision will be construed as providing less benefits in total for all such persons than would be provided if this provision had not been included.

D. EXPENSES ELIGIBLE FOR BENEFITS

1. Eligible Expenses

Eligible expenses will be the charges actually made to an Employee or eligible dependent on account of their illness for the services, treatments and supplies ordered by a physician described in this Paragraph 1.

(a) Room and board (including all regular daily services) in a hospital, except for room and board charges for each day of confinement in a private room which are in excess of the sum of (i) the hospital's standard semi-private room daily rate and (ii) $20.00. The provision covering room and board charges in a private room will also be applicable to confinements in a private room due to an occupational accident or illness.

(b) All other hospital services for medical care and treatment exclusive of professional services;

(c) Anesthesia and its administration;

(d) Local ambulance service;

(e) Physicians' services for medical care and treatment, surgery and acupuncture, excluding dental services.

(f) Private duty professional nursing services rendered by a registered graduate nurse or a licensed practical nurse other than a close relative or a nurse who ordinarily resides in the Employee's home;

(g) Restoratory or rehabilatory speech therapy or speech therapy to correct speech impairment due to a structural, physiological or neurological disorder as certified by a physician, whether or not congenital, rendered by a qualified speech therapist for speech loss or impairment upon the written recommendation of a physician.

(h) Audiological testing services by an audiologist upon the written recommendation of a physician.

(i) The following other services, treatments and supplies:

Oxygen and rental of equipment for its administration;

X-ray and laboratory examinations, x-rays unless rendered in connection with eligible dental surgical procedures;

Routine PAP tests;

Routine mammogram when performed once every two years between the age of 50 and 59 and annually upon attainment of age 60;

Treatments by x-ray and by radium or other substances, including Psoralen longwave ultraviolet light (PUVA) treatment;

Treatments by a physiotherapist other than a close relative;

The first routine hospital visit to a newborn child by a physician;

Surgical dressings;

Blood and blood plasma (unless replaced);

Artificial limbs, larynx and eyes;

Casts, splints, trusses, braces and crutches;

Purchase or rental of wheelchair, hospital bed, iron lung and similar equipment provided, in the case of purchase, that the criteria below have been fulfilled:

(i) the use of such equipment must be certified by the attending physician to be medically necessary,

(ii) the rental cost of the equipment for the period of use prescribed by the attending physician exceeds the purchase price.

Whenever the purchase price of the equipment exceeds $500, prior approval of the Company will be required.

(j) Room and board in an approved Convalescent Nursing Unit, and other services and supplies furnished by an approved Convalescent Nursing Unit for medical care, exclusive of professional services, if the covered individual has been confined in a hospital for at least 3 days and then admitted to such Convalescent Nursing Unit within 21 days following the hospital confinement upon the written recommendation of the attending physician certifying that the patient's condition would require hospital confinement if Convalescent Nursing Unit care were not available. Re-admission, upon the attending physician's recertification, to such Convalescent Nursing Unit within 14 days following discharge will be considered a continuation of the same confinement for purposes of this subparagraph (j).

Convalescent Nursing Home charges will be eligible for Major Medical Benefits only while the person remains under the continuous care of his physician and only for the period for which the physician certifies that twenty-four hour a day nursing care is essential. Convalescent Nursing Home charges shall be eligible for benefits up to a maximum of 330 days of confinement in a

Convalescent Nursing Home reduced by the number of days of confinement in a hospital or in a Convalescent Nursing Home for which benefits were paid or payable under the Employer's basic program of Hospital, Surgical and Medical Benefits for the same or related causes.

2. Modifications and Limitations

(a) Charges incurred by a covered individual for professional services rendered during a visit by or to a physician in connection with mental illnesses or functional nervous disorders of any type or cause of the covered individual other than visits which take place during a confinement of the covered individual in a hospital for which a room and board charge is made and other than visits during which convulsive therapy is administered, will only be included to the extent of $60.00 for professional services rendered during each such visit and only to the extent that such charges are incurred in connection with the first fifty of such visits during a benefit year.

The eligible expenses of this subparagraph shall also include charges for services of a clinical psychologist in connection with the diagnosis or treatment of any mental, psychoneurotic or personality disorder of a covered individual, subject to all limitations, exclusions and exceptions (including any limitation on the amount

of benefits payable therefor) which would apply if such services were rendered by a physician.

(b) Eligible expenses in Section D will only include charges for services, treatments or supplies which are reasonably necessary for the care and treatment of the illness and will not include charges for any services, treatments or supplies in excess of customary charges therefor or in excess of such charges as would have been made in the absence of this program. A customary charge means the usual charge made by the person, group or other entity rendering or furnishing the services, treatments or supplies but in no event will it mean a charge in excess of the general level of charges made by others rendering or furnishing such services, treatments or supplies, within the area in which the charge is incurred, for illnesses comparable in severity and nature to the illness being treated. The term "area", means a county or such greater area as is necessary to obtain a representative cross section of persons, groups or other entities rendering or furnishing such service, treatment or supply.

(c) A charge will be deemed to be incurred as of the date of the service, treatment, or purchase giving rise to the charge.

(d) The term "close relative" as used in Section D in connection with a registered graduate nurse, or a licensed practical nurse or a physiotherapist comprises the Employee, the Employee's spouse, and a child, brother, sister and parent of the Employee and of the Employee's spouse.

3. Exclusions and Ineligible Expenses

Eligible expenses will not include any of the following:

(a) Charges that would otherwise have been payable under the Medical Necessity Benefits Program if the employee and/or dependent had followed the required procedures for:

Pre-admission certification

Concurrent review after admission

Pre-admission testing

Weekend admissions

(b) Charges incurred in the event of an accident or sickness covered by a Workers' Compensation Act or similar legislation.

(c) Charges for eye refractions or examinations for the fitting of glasses or hearing aids.

(d) Charges for medical examinations of a covered individual for "check-up" purposes when not incident and necessary to the treatment of an illness.

(e) Charges incurred in connection with remedying a condition by means of cosmetic surgery unless such condition is the result of accidental bodily injuries sustained while a covered individual.

(f) Charges incurred during confinement in a hospital owned or operated by the United States Government or any agency thereof, except U.S. Veterans' hospitals for non-military service related medical conditions in which the veteran is legally required to pay for the medical services provided, charges for services, treatments or supplies furnished by or for the United States Government or any agency thereof, and charges incurred during confinement in a hospital owned or operated by a State, Province or political sub-division unless there is an unconditional requirement to pay these last mentioned charges without regard to any rights against others, contractual or otherwise.

(g) Charges incurred in connection with illnesses due to an act of war, including but not limited to, any war declared or undeclared, and armed aggression resisted by the armed forces of any country, combination of countries or international organization, if such act occurs while the Employee or eligible dependent is a covered individual.

(h) Charges for physicians' services in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, including treatment for temporomandibular joint (TMJ) dysfunction.

(i) Charges for physicians' services in connection with weak, strained or flat foot, any instability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for an open cutting operation or for services prescribed by a duly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

(j) Charges for physicians' services in connection with corns, calluses or toenails; unless the charges are for the partial or complete removal of nail roots or for services prescribed by a duly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is treating the patient for a metabolic or peripheralvascular disease.

(k) Charges incurred for services, treatments and supplies in connection with an illness of a covered individual, to the extent to which such services, treatments and supplies, or payment of such charges, or any benefit for or in connection with such charges, services, treatments or supplies, is provided for the

covered individual under or by any law or plan of any government or political sub-division (including Medicare), or under or by the Employer's basic program of Hospital, Surgical, Medical and Prescription Drug Benefits or any other plan which you participate by virtue of your employment with the Employer.

If, after benefits have been paid on account of services, treatments and supplies given to the Employee or eligible dependent in connection with an illness of such person, it is determined that any such services, treatments or supplies have been provided from any source referred to above, the Employer will be entitled to a refund from the Employee of the amount paid by it in connection with such illness which is in excess of the benefits which would have been payable based on the actual eligible charges incurred.

(l) Charges incurred for prescription drug co-payments or for prescription drug expenses in excess of the Plan allowance.

(m) Expenses incurred for private room accommodations which are in excess of the hospital's daily charge for a semi-private room plus $20.

(n) Services, supplies, and treatment prescribed by someone other than a physician.

(o) Services or supplies of common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, blood pressure kits, or supplies of a similar nature, even if prescribed by a physician.

(p) Custodial care, including accommodations, professional services, and nursing services needed only for daily living not for the treatment of an illness or injury.

(q) Services or supplies for training or education, such as pre-natal classes, diabetic training, etc., or for learning disabilities.

(r) Services provided by a member of your immediate family.

(s) Services or supplies provided by a sanitarium.

(t) Rest cures, travel, recreation or physician directed diversional therapy.

(u) Hospitalization for environmental change or charges connected with prescribing such a change.

(v) Private duty nursing for custodial purposes.

(w) Research studies and screening exams.

(x) Respiratory/inhalation therapy in an outpatient facility unless performed as part of the treatment for an accident,

illness, or surgery resulting from an emergency.

(y) Services or supplies used to treat conditions related to autism, hyperkinetic syndromes, learning disabilities, discipline problems or mental retardation, except to diagnose the condition.

(z) Sterilization reversals.

(aa) Certain services related to obesity and weight loss.

(bb) Nursing care associated with an inpatient stay, not billed as regular room and board charges.

(cc) Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

(dd) Any service or supply not covered in this Plan.

(ee) Care and supplies related to:

—artificial insemination;

—sex change operations;

—sterilization reversal;

—fertility treatment;

—immunizations.

(ff) Charges which an Employee is not legally required to pay.

(gg) Charges which exceed reasonable and customary charges.

(hh) Charges which would not have been made if an Employee had no insurance.

(ii) Charges for care, treatment, or surgery that is not medically necessary.

(jj) Services or supplies for experimental procedures or treatment methods.

(kk) Charges for an organ transplant in excess of the amounts set forth in Paragraph 3(a)(8) of Exhibit A-1.

E. COORDINATION OF BENEFITS

If an Employee or eligible dependent is also covered or is eligible to be covered as defined in Paragraph 19 of Exhibit A-1 under one or more other plans (as defined in subparagraph (d) below) the benefit payable under this program of Major Medical Benefits will be coordinated with the benefits payable under all other plans so that the sum of all benefits during any benefit year for such covered person will not exceed the total of such allowable expenses.

(a) When such other plan or plans have been determined to be primary (as defined in subparagraph (b) below), the benefit allowable under this program of Major Medical Benefits will be equal to the smaller of either:

(i) 100% of the Allowable Expenses less the amount payable by such other primary plan or plans, or

(ii) the amount of eligible expense benefit which would have been payable under this program of Major Medical Benefits had there been no such other plan or plans.

(b) Such other plan or plans will be considered as primary:

(i) when the eligible dependent is covered by such other plan, or

(ii) when an Employee, whose credited service is less with the Employer than with the employer sponsoring such other plan, is covered by such other plan as an employee, or

(iii) in any case, when such other plan does not contain a nonduplication or coordination of benefits provision.

(c) In those cases where both husband and wife are covered by a plan or plans, the plan covering the parent whose birthdate (month and day only) falls earlier in the calendar year will be considered as primary with respect to that parent and dependent children of the husband and wife and the parent whose birthdate (month and day only) falls later in the calendar year will be considered as primary for that parent and secondary with respect to dependent children of the husband and wife. If the husband and wife have the

same birthdate (month and day only), the plan covering the parent longer is primary with respect to the dependent children and the plan covering the other parent for the shorter time is secondary with respect to the dependent children.

When the plan of the Employee's spouse does not determine primary coverage for dependent children based on birthdate, the plan covering the husband as an Employee will be considered as primary with respect to the husband and his dependent children. The plan covering the wife as an Employee will be considered as primary with respect to the wife.

In the case when parents are separated or divorced and the parent with custody of dependent children has not remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the parent without custody.

In the case when parents are divorced and the parent with custody of dependent children has remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the stepparent. The dependent coverage of the stepparent will be primary to the dependent coverage of the parent without custody.

In the event there was a court decree which would otherwise establish financial responsibility for the medical care expenses with respect to dependent children, the dependent coverage of the parent with financial responsibility will be primary.

The Company shall establish reasonable procedures to determine the status of medical child support orders and to administer the payment of benefits under medical child support orders which are deemed to be qualified orders. Such procedures shall be in writing and shall comply with the provisions of Section 609 of the Employee Retirement Income Security Act of 1974, as amended.

(d) For purposes of this section on "Coordination of Benefits":

(i) Plan or plans mean any of the following providing benefits or services for medical or dental care or treatment or supplies: group insurance or other arrangement of coverage for individuals in a group, including prepayment coverage, group or individual practice coverage; coverage for students sponsored by or provided through an educational institution.

Medicare Parts A & B and any other Federal, State or government-sponsored hospital, surgical, medical or prescription drug program (including payments made under any "No Fault" Liability insurance program) and Goodyear Relief Association Coverage (but only such

coverage in excess of the applicable deductible under this plan during the benefit year) will be considered as though such programs were identical in status to the Employer's basic program of hospital, surgical, medical, dental and prescription drug benefits. For purposes of this sub-paragraph, an Employee, Pensioner, or eligible Surviving Spouse, and their eligible dependents, who are eligible to receive the Special Medicare Benefit provided in Paragraph 16 of Exhibit A-1 of this Agreement shall be considered covered under Part B of Medicare whether or not such person has actually enrolled for coverage under Part B of Medicare.

(ii) Allowable Expenses means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom a claim for benefits is made.

(iii) When an Employee (including the dependent children of such Employee), the spouse of an Employee (including the surviving spouse or a surviving dependent of a deceased Employee) elects coverage under a Group Practice Plan or a Health Maintenance Organization Plan, benefits otherwise payable under this Program except as described below will not be paid and Coordination of Benefits

provisions described in this Paragraph B will not be applicable.

If, however, a spouse of an Employee (including the surviving spouse of a deceased Employee) is provided employer-sponsored coverage under a Group Practice Plan or a Health Maintenance Organization Plan as the only available medical plan, benefits otherwise payable under this Program will be paid and Coordination of Benefits provisions described herein will be applicable.

(iv) Notwithstanding any provisions in the above paragraphs to the contrary, when an Employee and spouse are both employed by the Company and eligible for medical benefits, each individual must elect medical coverage in his or her own right providing there is such coverage available to one of the Employees on a non-contributory basis consistent with this Paragraph E.

F. SUBROGATION

1. In the event an Employee or eligible dependent is legally entitled to recover all or a portion of the cost of an eligible expense covered by this program of Major Medical Benefits from a third party, the Employer will, upon making payment under Major Medical Benefits, succeed to any rights of recovery the Employee or eligible dependent may have or acquire (with respect to such eligible

expense) against any person or organization except insurors of individual hospital, surgical, or medical policies issued to the Employee or eligible dependent.

2. Employees (including eligible dependents) by acceptance of such benefit payments agree to furnish such information and assistance, and execute such assignments and other instruments as the Employer may reasonably request to facilitate enforcement of the successor rights of the Employer. Employees and their eligible dependents shall take no action prejudicing such rights of the Employer.

G. OVERALL BENEFIT MAXIMUMS

1. Individual Maximums

   (a) An annual maximum of $100,000 of benefits will be payable with respect to all charges incurred for all illnesses of any one covered during a benefit year.

   (b) A lifetime maximum of $400,000 of benefits will be payable with respect to all charges incurred for all illnesses during the entire duration of coverage for any one covered individual.

2. Individual Maximum Re-established

   With respect to illnesses of the Employee or eligible dependent, if benefits of $1,000.00 or more of the Individual Maximum became payable, the Individual Maximum may be

re-established to such person by the Employee furnishing satisfactory evidence of recovery from such illness or illnesses of the person for whom the Individual Maximum is being re-established. If these conditions are satisfied, the Individual Maximum will be applied to such person as though no Major Medical Benefits became payable with respect to the illness of illnesses of such person prior to the date such reapplication[ ] is effected.

H. MODIFIED COVERAGE FOR EMPLOYEES RETIRED ON PENSION

Employees who retire with 10 or more years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan) shall receive the Major Medical Benefits described in this Exhibit A-2, subject to the modifications described below; provided, however, that each Employee eligible under the 1950 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

Employees who retire with less than 10 years of continuous service and who are eligible for and receiving a monthly pension under the 1950

Pension Plan for a pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan) may elect to receive the benefits described in this Exhibit A-2, subject to the modification described below, by payment in advance of the Group Rate as estimated by the Company annually in advance.

Employees hired after April 23, 1988 and who retire after completion of at least 20 years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan), shall receive the Major Medical Benefits described in this Exhibit A-2, subject to the modifications described below.

Employees hired after April 23, 1988 and who retire after completion of at least 10 years of continuous service but less than 20 years of continuous service and who are eligible for and receiving a monthly pension under the 1950 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1950 Pension Plan), shall receive Major Medical Benefit amounts equal to 50% of the benefits described in this Exhibit A-2, subject to the modifications described below; provided, however, that such retired Employee may elect to continue the full benefits of this Exhibit A-2 by payment in advance of 50% of the Group Rate as estimated by the Company annually in advance.

Notwithstanding the above, Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1950 Pension Plan whose full years of attained age and full years of attained continuous service at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of the benefits described in this Exhibit A-2. An Employee earns one point for each year of attained age and one point for each year of attained continuous service. Total points are derived by adding together the attained age and attained continuous service points. Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the benefits described in this Exhibit A-2. Failure to pay the required medical contribution will result in cancellation of coverage.

An Employee who retires with thirty (30) or more years of service at any age will receive 95 points at retirement.

An Employee who retires with a disability pension with ten (10) or more years of service will receive an additional 30 points at retirement.

An Employee who does not preferentially hire and subsequently retires as a result of a plant closure will receive an additional 15 points at retirement.

An Employee who, on January 1, 1996 is:

(a) Age 50 or older and has 10 or more years of continuous service but less than 30; or

(b) Any age and has 20 or more years of service but less than 30;

will receive an additional 15 points which will be added to the Employee's point total at the time of their retirement.

As an alternative to the above, an Employee required to make the described health care contribution may elect, at the time of retirement, a catastrophic medical plan option based on the benefits described in Exhibit B-1 of the Pension, Insurance and Service Award Agreement dated April 29, 1994. The deductible under this option shall be $1,000 per covered individual per year, $2,000 per family per year, 80% Company co-payment, 20% retiree co-payment and a retiree co-payment maximum (after the deductible is satisfied) of $1,000 per covered individual, or $1,500 per family per year. There is no health care contribution required for this option.

A retired employee required to make a health care contribution as described above shall be afforded the opportunity to change his medical plan option election in the event there is a change in the amount of the retiree medical contribution required or there is a change in the plan design.

The amount of "Individual Maximums" applicable to a retired Employee or eligible dependent

after the Employee's date of retirement will be the lesser of either:

(a) $200,000 or

(b) the balance of the Individual Maximum remaining to the credit of the covered individual on the Employee's date of retirement.

I. TERMINATION OF COVERAGE

Major Medical Benefits will terminate coincident with and under the same terms and conditions as the termination of coverage under the Medical Necessity Benefits Program as described in Exhibit A-1 of this Agreement including all the provisions relating to Layoff, Leave of Absence, Leaves due to Injury or Sickness, Retirement, Death and Exiting from the Employer.

Extension of benefits following termination of coverage, applicable to the Medical Necessity Benefits Program, will also be applicable to Major Medical Benefits.

J. MISCELLANEOUS PROVISIONS

1. Assignment

Major Medical Benefits may be assigned at the request of the Employee. Benefits may be paid to either the Employee or the provider as elected by the Employee upon receipt of proof of claim.

2. Proof of Claim

Written proof of charges upon which claim may be based must be furnished within 12 months after the end of the benefit year in which the charges were incurred. Failure to furnish proof within the time stated will not invalidate nor reduce any claim if it can be shown that the delay was unavoidable and that such proof was furnished as soon as was reasonably possible.

3. Medical Examination by Employer

The Employer will have the right and opportunity to examine the covered individual whose injury or sickness is the basis of claim when and so often as it may reasonably require during pendency of claim.

* * *

LETTER #11

July 20, 1994

Mr Ron Hoover
URW Goodyear Coordinator
United Rubber, Cork, Linoleum and
Plastic Workers of America,
AFL-CIO-CLC
570 White Pond Drive
Akron, Ohio 44320

Dear Mr Hoover:

Reference is made to the Medical Necessity Benefits Program, Major Medical Benefits Program and

Employee Savings Plan Without Matching Contributions as well as the Comprehensive Medical Benefits Program and Employee Savings Plan for Bargaining Unit Employees, as provided in the Pension, Insurance and Service Award Agreement dated May 15, 1991.

It is hereby agreed that from July 20, 1994 through December 31, 1994, the Medical Necessity Benefits Program, Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions or Comprehensive Medical Benefits Program for Employees and their Dependents, and Employee Savings Plan for Bargaining Unit Employees will continue to be provided under the Pension, Insurance and Service Award Agreement dated May 15, 1991. It is further agreed that Employees who retire prior to January 1, 1995 shall be afforded a choice to elect either the Medical Necessity Benefits Program/Major Medical Benefits Program or the Comprehensive Medical Benefits Program with coverage to be effective on the date of their retirement.

Sincerely yours,

Director, Industrial Relations
(sgd)J M Warren

Agreed:
(sgd)Ron Hoover

(Original letter dated May 2, 1985
from P R Tully to Stanley Somo)

LETTER #14

July 20, 1994

Mr Ron Hoover
URW Goodyear Coordinator
United Rubber, Cork, Linoleum and
Plastic Workers of America,
AFL-CIO-CLC
570 White Pond Drive
Akron, Ohio 44320

Dear Mr Hoover:

During the course of the 1994 Companywide negotiations, the parties discussed the continuation of the Medical Necessity Benefits Program, Major Medical Benefits Program and the Employee Savings Plan Without Matching Contributions.

It was agreed between the parties that the Company will continue to make the above stated benefits available through April 19, 1997, and further that these benefits will terminate upon the expiration of the 1994 Pension, Insurance and Service Award Agreements.

Sincerely yours,

Director, Industrial Relations
(sgd)J M Warren

Agreed:
(sgd)Ron Hoover

AGREEMENT

Between

Shell Chemical Company
Point Pleasant Polyester Plant

and

Local No. 644

of the

United Rubber, Cork, Linoleum and
Plastic Workers of America
A.F.L.—C.I.O.

Effective November 6, 1994

* * *

ARTICLE XV
EFFECTIVE DATE
AND TERMINATION

Section 1

This Agreement shall become effective November 6, 1994 and shall continue in effect until 12:01 a.m. November 6, 1997. Thereafter it shall renew itself for yearly periods unless written notice is given by either party to the other not less than sixty (60) days but not more than seventy-five (75) days prior to the expiration date or any extension thereof that is desired to terminate or amend the Agreement. In the event such notice is given, the parties shall begin negotiations within forty-five (45) days prior to 12:01 a.m. November 6, 1997. At the opening of such

negotiations both parties shall present to each other in writing their proposed changes in said Agreement. If negotiations are not completed prior to the expiration date, this Agreement shall terminate unless extended by mutual agreement of the parties.

Section 2

In the event that right, title or possession to the plant covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale or any other method of disposition or acquisition, this Agreement shall be binding upon the Company and its successors and assigns.

* * *

LETTERS OF INTENT

Letter A

November 6, 1994

September 2, 1994

Mr. Don Rollins
President
URW Local 644
2611 Lincoln Ave
Point Pleasant, WV 25550

Dear Don,

Confirming our earlier discussions, the Company and the Union agree that for the duration of our Articles of Agreement which continue in effect until 12:01 a.m., November 6, 1994, and for the term of our next

Agreement, the benefit plans currently applicable to employees you represent at the Point Pleasant Polyester Plant will be continued, subject to the changes shown in the attachments.

The parties agree to implement these changes to benefit plans on the date shown even if such effective dates fall beyond the term of our next Agreement, provided the benefit plan affected is applicable to union represented employees at that time.

It is also understood that the parties may wish to discuss modifications to the attached Agreements during upcoming negotiations, but that if the parties are unable to reach agreement on such modifications, the understandings covered by this Letter Agreement will remain as is.

Sincerely,

W. D. Wunder
Manager Human Resources

ks

PENSION, INSURANCE AND SERVICE AWARD AGREEMENT

Effective May 9, 1997

Between

Shell Chemical Company
Point Pleasant Polyester Plant

and

Local Union 644

of the

United Steelworkers of America,
AFL-CIO-CLC

FORWARD [sic]

The following pages contain the Pension, Insurance and Service Award Agreement dated May 9, 1997, by and between Shell Chemical Company and United Steelworkers of America, and the Local Unions thereof listed therein, effective May 9, 1997.

Upon the adoption of the amendments to the 1993 Pension plan of Shell Chemical Company provided for in the Pension, insurance and Service Award Agreement dated May 9, 1997, the full text of the 1993 Pension Plan, as applicable to Employees covered by said Agreement who are also covered by the Plan and who retire on or after May 1, 1997, will be as set forth in the Exhibit A appearing at the end hereof.

PENSION, INSURANCE, AND SERVICE AWARD AGREEMENT

THIS AGREEMENT is made and entered into this 9th day of May, 1997, by and between the SHELL CHEMICAL COMPANY, covering the plants operated by it as listed below, and UNITED STEELWORKERS OF AMERICA, and the local unions thereof listed below.

Wherever used in this Agreement.

(A) The term "Basic Agreement" means the present agreement dated May 9, 1997, between the parties hereto, or any new agreement, replacing such present agreement, hereafter entered into between the parties hereto; and the term "1994 Agreement" means the Pension, Insurance and Service Award Agreement entered into between the parties on July 20, 1994;

(b) The terms "Company" and "Employer" each mean the SHELL CHEMICAL COMPANY;

(c) The term "Employee" means any employee of the Employer who, during the term of this Agreement, shall be in a bargaining unit covered by the Basic Agreement;

(d) The term "Union" means the UNITED STEELWORKERS OF AMERICA, and

(e) The term "Local Union" means, as to each plant covered by this Agreement, the respective local union listed below which is the exclusive bargaining agency of the employees in certain bargaining units at such plant.

This Agreement is executed by representatives of the Union and by members of the International Policy Committee who represent the Local Unions involved.

The plants covered by this Agreement and their respective Local Unions are as follows:

Plant	Local Union
Akron and Stow Plants	2
Gadsden Plant	12
St. Mary's Plant	200
Lincoln Plant	286
Topeka Plant	307
Danville Plant	831
Marysville Plant	843
Union City Plant	878
Sun Prairie Plant	904
Point Pleasant Plant	644

* * *

PART V

INSURANCE

Section A—Basic Life Insurance, Accidental Death and Dismemberment Insurance, Optional Contributory Life Insurance, and Survivor Income Benefits

Effective *May 9, 1997*, and for the duration of this Agreement thereafter, the Employer will provide the following standard form basic life insurance, accidental death and dismemberment insurance, optional contributory life insurance, and survivor income benefits for regular full time Employees beginning on the 31st day of employment:

1. Basic Life Insurance and Accidental Death and Dismemberment Insurance.

   (a) The amount of basic life insurance benefit for each Employee shall be *$35,000* and the amount of accidental death and dismemberment insurance shall be *$35,000*.

   Effective April 23, 2000 the amount of basic life insurance benefit for each Employee shall be $40,000 and the amount of accidental death and dismemberment insurance shall be $40,000.

   The amount of insurance payable in the event of the death of the Employee will be payable to the named beneficiary in accordance with the terms described in this Program.

(b) The full amount of basic life insurance benefits will be payable to the beneficiary in the event of the death of the Employee from any cause, at any place and at any time while insured under the Program.

(c) The full amount of the accidental death and dismemberment insurance benefit shall be payable if an accident causes the loss of:

Life
Both hands
Both feet
One hand and one foot
One hand and sight of one eye
One foot and sight of one eye
Sight of both eyes

One-half of such amount shall be payable if an accident causes the loss of one hand, one foot, or the sight of one eye; provided, however, that the full amount will be paid only once to or on account of any Employee.

The amount of insurance, subject to due proof of claim loss, will be payable to the Employee if living, otherwise to the beneficiary in accordance with the terms described in this Program.

Accidental death and dismemberment insurance benefits will be payable upon due proof that such loss resulted, directly and independently of all other causes, from bodily injuries caused by an accident occurring while the Employee was covered by this Program.

With respect to a hand or a foot, "Loss" means dismemberment by severance through or above the wrist or ankle joint. With respect to an eye, "Loss" means the entire and irrecoverable loss of the sight of such eye. With respect to losses involving partial loss of a bodily member or the partial loss of the sight of an eye, "Loss" shall also mean the loss of all functional use of the hand, foot or eye.

Accidental death and dismemberment insurance does not cover any loss caused directly or indirectly, wholly or partly, or contributed to substantially, by bodily or mental infirmity, or ptomaines, or bacterial infections (except pyogenic infections which occur through an accidental cut or wound); or any other kind of disease; or medical or surgical treatment (except such as may result directly from surgical operations made necessary solely by injuries); or war, or any act of war; or suicide, sane or insane.

(d) BENEFICIARY.

(i) The Employee may designate a beneficiary or beneficiaries or change the designation of such beneficiary or beneficiaries from time to time by written notice on form provided by the Employer. Such designation or change will take effect as of the date of execution of such request but without prejudice to the Employer on account of any payments made prior to receipt of such request.

If any designated beneficiary predeceases the Employee, the share which such beneficiary would have received if surviving the Employee will be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the Employee.

If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made to the Employee's spouse, if surviving the Employee; if not surviving the Employee, in equal shares to the Employee's children who survive the Employee; if none survives the Employee, to the Employee's parents, equally, or to the survivor; if neither survives the Employee, in equal shares to the Employee's brothers and sisters who survive the Employee; or, if none survives the Employee, to the Employee's executors or administrators.

In any case, the Insurance Company may, on instructions from the Employer, deduct from the benefits payable an amount not to exceed $1,000 to cover expenses incurred for the Employee's burial.

(ii) Payment of death benefits will be made in one sum upon proof of claim. The beneficiary may, after death of the Employee but before payment is made, elect that the whole or any part of the benefit be payable in accordance with method

(1) or (2) below or in accordance with such other method of settlement as shall be elected by the beneficiary and agreed to by the Insurance Company.

(1) Payment in equal monthly installments extending over a fixed period of years. The fixed period of years must be specified in the election and may not exceed twenty, and in no event will the Insurance Company be required to pay an installment of less than $10.00 to any one person.

(2) Payment in monthly installments of any fixed amount specified in the election (which may not be less than $5.00 per month per $1,000 so payable nor less than $10.00 per month regardless of the amount so payable), until the amount so payable with interest is exhausted. With respect to each such election, the rate of interest to be allowed on the unpaid balance shall be determined by the Insurance Company but shall in no case be less than 3% per annum.

At the death of a beneficiary to whom a death benefit claim is being paid under method (1) or (2) above, the present value of any unpaid installments under method (1) above, commuted on the basis of 3% interest per annum, or any unpaid balance under method (2) above, as the case may be, will be paid in one sum

to the executors or administrators of the beneficiary.

(e) The insurance coverage described in Paragraph 1(a) of this Section A shall be likewise provided for any Employee absent on the Effective Date, under a leave of absence granted by his Employer, and the insurance coverages provided to any Employee in accordance herewith shall be continued in force during the period of any absence for which he is granted a leave of absence by his Employer, except in cases where such Employee is employed by a Local Union in other than an official or representative capacity, or is employed in any capacity by the International Union.

(f) If an Employee for whom insurance coverages are provided in accordance herewith shall be retired on a disability pension under the 1993 Pension Plan, the full amount of his basic life insurance (but not his accidental death and dismemberment insurance) shall be continued in force for the period of such disability (subject to the furnishing of due proof of its continuance) or until he attains age 65, whichever first occurs. In the event such disability continues after attainment of age 65, the amount of basic life insurance shall be reduced on the first day of the month following the month in which he attains age 65 and on the first day of each succeeding month thereafter by an amount equal to 1/30th of the difference between $2,250 and the amount of basic

insurance in effect at the time of his retirement; provided, however, that such monthly reductions shall not operate to reduce the amount of basic insurance below a minimum amount of $2,250, which minimum amount shall then be continued in force during such Employee's remaining lifetime.

(g) Except as provided herein, all insurance coverages provided hereunder for any Employee, other than a laid-off Employee, shall cease on the date 31 days following any termination of such Employee's active employment; all insurance for a laid-off Employee shall cease on the date 90 days following termination of active employment; provided, however, that the basic life insurance (but not the accidental death and dismemberment insurance) benefit shall be continued in force for all Employees who retire and receive a monthly pension under the normal or early retirement provisions of the 1993 Pension Plan, and for all Employees who receive a Service Award (as distinguished from a Service Award Monthly Benefit and any benefit payable under Articles XII and XIII) under the 1993 Pension Plan subject to reduction on the first day of the month following the month in which he receives a Service Award, or in the case of normal or early retirement, retires or attains age 62, whichever later occurs, and on the first day of each succeeding month thereafter in an amount equal to 1/30th of the difference between $2,250 and the amount of basic insurance in effect at the time of his retirement until the amount of

basic insurance is reduced to a minimum coverage of $2,250; provided, however, that for Employees who continue in employment after attaining age 65 and retire with a normal, retirement pension, his amount of basic life insurance on the first day of the month following the month of retirement shall be determined as if he had retired upon attainment of age 65 with the applicable reductions from age 65; and provided further that in the case of any other Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated at or after his attainment of age 60, basic life insurance (but not accidental death and dismemberment insurance) coverage in the amount of $2,250 shall be made effective with respect to such Employee as of the first day of the month for which he receives a deferred vested pension, and shall thereafter be continued during his lifetime. If an Employee returns to active employment within such time and under such circumstances that he is credited with previous service in accordance with the Basic Agreement, insurance shall be immediately provided for him in the amounts set forth in Paragraph 1(a) of this Section A.

A laid-off Employee may, within 90 days following layoff, arrange to continue the full amount of his basic life insurance coverage and accidental death and dismemberment insurance by payment in advance at the rate of $0.55 per $1,000 of insurance per month for the period equal to the maximum number

of full weekly SUB benefits to which Employee's credit units as of last day worked prior to lay-off would entitle him under the Supplemental Unemployment Benefits Plan but not less than 24 months following the date of layoff, provided, however, that upon acceptance of any benefit payable under Article XIII of the 1993 Pension Plan, the Employee shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this sub-paragraph (g).

(h) Conversion Privilege. In case of termination of insurance coverage for any reason whatsoever, the Employee will be entitled to have a policy of life insurance issued by the Insurance Company without further evidence of insurability, provided:

(i) the amount of the policy may not exceed the amount of the Employee's life insurance under the Program at the time the coverage terminated,

(ii) the policy must be upon one of the non-participating forms then customarily being issued by the Insurance Company, except Term Insurance,

(iii) the policy will require payment of the premium applicable to the class of risk to which the Employee then belongs and to the form and amount of the policy at the Employee's then attained age,

(iv) written application for such a policy and payment of the first premium must be made by the Employee within thirty-one days after termination of such coverage and such policy will become effective at the end of such thirty-one days.

The Employee whose insurance is reduced because of (1) being retired on pension, (2) being granted a service award, or (3) attaining age sixty-five while retiree on a disability pension under the 1993 Pension Plan will, to the extent set forth below, be entitled to the rights granted under this section:

(i) If the Employee's insurance is, in accordance with the terms of the Program subject to only one such reduction, the Employee will be entitled to said rights, as to the amount of the reduction, as though coverage had terminated on the date of the reduction in insurance.

(ii) If the Employee's basic insurance is, in accordance with the terms of the Program subject to more than one such reduction, the Employee will, on the day of the first such reduction and on the first day of the sixth, twelfth, eighteenth, and twenty-fourth calendar months following the day of the first reduction, be entitled to said rights, in an amount equal to one-fifth of the difference between $2,250 and the amount of insurance in effect at the time of his retirement, as

though the Employee's coverage had terminated on that day.

(iii) If the Employee's Optional Contributory Life Insurance is, in accordance with the terms of the Program, subject to more than one such reduction, the Employee will, on the day of the first such reduction and on the first day of the fourth, seventh, and tenth calendar months following the day of the first reduction, be entitled to said rights, in an amount equal to 25% of the amount of insurance in effect at the time of his retirement, as though the Employee's coverage had terminated on that day.

If the Employee fails to exercise any conversion right from a reduction in the amount of his insurance, the Employee will not, thereafter, be entitled to convert the amount of any subsequent reduction in the amount of his insurance.

If the Employee dies during the thirty-one day period within which he is entitled to have an individual policy issued to him under the conversion privilege and before any such individual policy has become effective, the amount of life insurance which the Employee is entitled to have issued to him under such individual policy will be payable as a claim under the Program, whether or not application for the individual policy or the payment of the first premium therefore has been made.

(i) It is the intent of this Paragraph 1 that Employees shall be provided, beginning *May 9, 1997*, without cost to them, with the basic life insurance and accidental death and dismemberment insurance benefits previously provided under existing group insurance plans underwritten by Aetna Life Insurance Company, including the benefit increases provided in Paragraph 1(a) of this Section A.

(j) Assignment—Claims of creditors. Neither the Employee nor the beneficiary may assign the insurance or other benefits under this Program.

Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under the program shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Employee or his beneficiaries.

Optional Contributory Life Insurance.

(a) Employees who are covered for Basic Life Insurance benefits will also be eligible to enroll for and be covered by Optional Contributory Life Insurance.

(b) Eligible Employees must enroll and authorize deductions of contributions for Optional Contributory Life Insurance based upon the following schedule:

CONTRIBUTION PER $1,000

Of INSURANCE

Age	Per Month
Under 30	$.25
30 - 34	.30
35 - 39	.35
40 - 44	.40
45 - 49	.45
50 - 54	.50
55 - 59	.55
60 - 64	.60
65 - 69	.70
70 and over	.80

(Monthly contributions will be based on Employee's current age)

(i) The initial enrollment period will be the thirty-one (31) days following the Effective Date and the coverage will become effective upon enrollment.

(ii) For Employees hired after the Effective Date, coverage will become effective on the day the Life Insurance, pursuant to Paragraph 1 of this Section A becomes effective, provided the Employee enrolled on or prior to that date.

(c) A medical examination at the Employee's expense may be required to provide evidence of insurability satisfactory to the carrier:

(i) if the Employee does not enroll during the enrollment periods described in (i) of subparagraph (b) above;

(ii) if an Employee hired after the Effective Date does not enroll within thirty-one (31) days after becoming eligible;

(iii) if an Employee who elected an amount equal to 50%, 100% or 200% of Basic Life Insurance elects an increased amount.

(iv) or if the Optional Contributory Life Insurance previously terminated because an Employee revoked the required payroll deduction authorization.

(d) Employees enrolled for Optional Contributory Life Insurance may elect to be insured for an amount equal to 300%, 200%, 100% or 50% of their Basic Life Insurance.

Employees enrolled for Optional Contributory Life Insurance will be provided with Dependent Life Insurance as follows:

For Employees electing 300% of coverage:

Spouse	$20,000
Child	$ 7,000

For Employees electing 200% of coverage:

Spouse	$15,000
Child	$ 5,000

For Employees electing 100% of coverage:

Spouse	$10,000
Child	$ 3,500

For Employees electing 50% of coverage:

Spouse	$ 5,000
Child	$ 2,000

(i) A "dependent" means the Employee's spouse, if married at least a year prior to death or the Employee's unmarried child at least six months of age but under nineteen years of age, however, any person who is in full-time military service shall not be considered a dependent.

(ii) A "child" means the Employee's own natural or legally adopted child or step child who lives with either parent and depends upon the Employee for support and maintenance.

The word "child" means in addition to the Employee's own children as defined above, such foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, or marriage, such dependent shall not become eligible until three months have elapsed from the date such child was added to the Employee's medical enrollment.

(iii) The amount of insurance payable under the Dependent Life Insurance provision shall be payable to the Employee in the

event of death of the Dependents from any cause.

(e) Optional Contributory Life Insurance is payable in event of death from any cause while an Employee is insured. The insurance will be paid to the beneficiary designated by the Employee under the Basic Life Insurance and Accidental Death and Dismemberment Insurance plan.

(f) The Optional Contributory Life Insurance coverage shall cease on termination of an Employee's active employment, including any layoff or retirement.

However, Employees who retire and receive a monthly pension with a normal, disability or early-retirement pension under the 1993 Pension Plan and who have made all contributions required in the 24-month period immediately preceding the date of retirement will have the Employee's and his dependent's insurance continued without payment of monthly contributions in accordance with the following schedule:

PERIOD AFTER RETIREMENT FOR WHICH EMPLOYEE'S INSURANCE WILL BE CONTINUED WITHOUT CONTRIBUTIONS	PER CENT OF OPTIONAL CONTRIBUTORY LIFE INSURANCE IN EFFECT AT RETIREMENT TO BE CONTINUED
1st through 3rd month	100%
4th through 6th month	75%

7th through 9th month	50%
10th through 12th month	25%

Moreover, commencing with the 13th month after retirement the Employee's insurance, but not the Dependent's insurance, will be continued during the Employee's remaining lifetime, provided such Employee also has made all contributions required for the 120 months immediately prior to the date of retirement, in accordance with the following schedule:

Amount of Coverage Elected	Amount of Insurance Continued
300%	$ 6,400
200%	$ 4,900
100%	$ 3,400
50%	$ 2,400

In no event, however, will the amount to be continued be based on any increase in the amount of insurance which the employee voluntarily elected within the 24-month period immediately preceding date of retirement.

Employees who are covered for Basic Life Insurance, pursuant to Paragraph 1 of this Section A, during layoff, leave of absence, or sick leave, may while so covered, also continue the Optional Contributory Life Insurance coverage by making arrangements for the required monthly contributions to be paid directly to the Employer. Optional Contributory Life Insurance coverage will also terminate if the Employee fails to make the required contributions within thirty-one (31) days following written notice of contributions due, mailed to the last address on file with the

Employer. Optional Contributory Life Insurance is subject to the conversion privilege upon termination of such insurance.

* * *

SECTION B – Comprehensive Medical Benefits Program and Employee Savings Plan for Employees and Their Dependents

Effective January 1, *1998* and for the duration of this Agreement thereafter, the Employer will provide a Comprehensive Medical Benefits Program and Employee Savings Plan as described in Exhibit B attached hereto and made a part hereof by reference.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

An Employee who retires and receives a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1993 Pension Plan) and is eligible for benefits under Exhibit B shall have his medical benefits after retirement provided under Exhibit B; provided, however, that each Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Effective January 1, 1989, and consistent with the provisions of COBRA and any subsequent amendments thereto, the Company will make available the options for continuation of health care coverage prescribed by COBRA, to employees, spouses, former employees, former spouses and former eligible dependents. The medical benefit continuation options prescribed by COBRA shall be concurrent with any continuation of benefits otherwise provided in this Section B and Exhibit B-1.

* * *

6. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 6 is provided in lieu of all other coverage under Part V. Section A of the Agreement and Exhibit B-1. However, upon termination of coverage under this Paragraph 6, the conversion privileges of Part V. Section A, Paragraph 1 of the Agreement and Exhibit B-1 as well as the termination provisions of Exhibit B-1 shall apply.

Coverage under Part V. Section A of the Agreement will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of Section A. Coverage under Exhibit B-1 will be extended following such Plant Closure without cost to the Employee for an additional

12 months beyond Employer-furnished coverages provided in Exhibit B-1. However, in no event shall the coverage provided in Exhibit B-1 be less than 9 months. For any month in which Employer-furnished coverage is provided under Paragraph 1, Part V Section A of the Agreement, the Employee may continue to purchase coverage under Paragraph 2 of Section A.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Shell Supplemental Unemployment Benefits Plan, coverage under Exhibit B-1 may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 6 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 and 36 consecutive months for coverage under Exhibit B-1 following the month in which such Plant Closure occurred.

Coverage under this Paragraph 6 will not continue as provided above while the Employee is covered by any other Employer sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such

coverage continuously except as provided above in this Paragraph 6.

PART VI

DURATION AND TERMINATION

1. Subject to the conditions set forth in Part II hereof, this Agreement shall become effective as otherwise set forth in this Agreement, upon approval by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union, and shall then supersede the *1994* Agreement. Should this Agreement not have been approved by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union prior to *May 30, 1997*, all references in this Agreement (and the Exhibits hereto) to *May 9, 1997*, shall be construed to refer to the date as of which such approval is given.

2. This Agreement constitutes a settlement for the duration of this Agreement of all issues with respect to the subject matters covered hereby, and, while this Agreement continues in effect, the Employer shall have no obligation to negotiate or bargain with the International Union or any Local Union (except as noted in connection with grievance procedures) with respect to any subject matter covered hereby, nor shall there be any strike or work stoppage with respect to such matters. Any termination of the Basic Agreement in accordance with the provisions thereof shall not affect the duration of this Agreement nor shall

such termination of the Basic Agreement be deemed to open for negotiation the subject matters covered by this Agreement. The fact that this Agreement continues in effect shall not prevent the parties from engaging in a strike or lockout with respect to any subject matter not covered by this Agreement, if such strike or lockout may be engaged in lawfully under the terms and provisions of the Basic Agreement.

3. The International Union or the Employer may request renegotiation of the provisions of this Agreement and termination of the Basic Agreement and local supplements thereto by giving a written notice to the other party not more than 75 days nor less than 60 days prior to *May, 9, 2003*, or any *May 9* thereafter. In such event, if negotiations are not completed prior to the *May 10* next following the giving of such written notice, this Agreement, together with the Basic Agreement and local supplements thereto shall terminate unless otherwise agreed upon.

4. In the event at any time the Basic Agreement and the local supplements thereto shall have been terminated as a result of the termination of this Agreement as provided in the preceding Paragraph 3 and the parties shall subsequently settle the issues involved in this Agreement which resulted in the termination thereof, the Basic Agreement and the local supplements thereto shall be immediately reinstated in full force and effect.

5. This Agreement may be amended by mutual agreement between the parties. If either party proposes amendments to this agreement during the life thereof, negotiations on such proposals shall begin within thirty (30) days. If no settlement is reached, the provisions of this Agreement shall continue in effect.

6. In the event that right, title or possession to any or all of the plants covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale, or any other method of disposition or acquisition. The benefits provided in this Agreement shall be binding upon the Company and its successors and assigns.

* * *

EXHIBIT B

COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS AND THE EMPLOYEE SAVINGS PLAN FOR BARGAINING UNIT EMPLOYEES

EXHIBIT B-1

SHELL CHEMICAL COMPANY COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January 1, 1998, and for the duration of this Agreement thereafter, the Employer will provide the following program of hospital benefits, hospital-medical benefits, surgical benefits and prescription drug benefits for eligible employees and their dependents, with the exception that none of the aforesaid benefits shall be applicable in the event of

accident or sickness covered by a Workers' Compensation Act nor shall there be any duplication of benefits under any Employer-sponsored Program.

1. Benefits

(a) General.

Benefits will be payable in accordance with the provisions of Paragraphs (b), (c), and (d) below, for eligible charges authorized by a doctor licensed to practice medicine which are reasonably necessary for the care and treatment of a non-occupational accident or illness of an Employee or eligible dependent.

(b) Amounts.

The benefits specified below will be payable with respect to eligible charges which are incurred during a benefit year, exclusive of the charges used to satisfy the deductible applicable to the benefit year.

(1) 85% *(90% when care is received from a Select Provider)* of all eligible charges incurred in connection with mental illness or functional nervous disorders of any type or cause other than charges incurred in connection with the administration of convulsive therapy and other than charges incurred during a confinement in a hospital for which room and board charge is made and only to the extent that such charges are incurred in connection with the first fifty of such visits during a calendar year.

(2) 100% of eligible charges for out-patient surgery (including the facility charge).

(3) The physician's professional opinion charge for the Second Surgical Opinion is paid at 100%.

(4) 100% of eligible charges for Pre-Admission Testing (PAT) that is performed under an approved PAT program of the hospital in which surgery is to be performed.

(5) 85% *(90% when care is received from a Select Provider)* of all other eligible charges, exclusive of any charges with respect to which benefits are payable under subparagraphs (1), (2), (3) and (4) above.

(c) Deductible.

(1) The deductible applicable to a covered individual for each benefit year will be *$175*.

(2) The eligible charges used to satisfy the deductible applicable to a covered individual for a benefit year will be the first eligible charges incurred during the benefit year in an amount equal to the deductible.

(3) If at any time during a benefit year the deductible applicable to such benefit year is individually satisfied, in accordance with subparagraphs (1) and (2) above for any three members of a family

unit, or if the aggregate deductible amount for members of a family unit equals *$350*, the deductible applicable to all other members of a family unit for such benefit year shall also be considered to have been satisfied.

The term "family unit" as used herein shall mean an Employee, spouse, and eligible dependent children.

(d) Co-payment Maximum

The co-payment maximum shall apply to those eligible expenses which are eligible to be reimbursed at 85% *(90% when care is received from a Select Provider)* as described in paragraphs 2 and 4 below. This maximum is a limit of $750 per covered individual or $1,100 per family per year, whichever shall first occur, on the amount of 15% *(10% when care is received from a Select Provider)* co-payments an individual or family must pay in a benefit year. Once this $750 individual or $1,100 family limit is reached in a benefit year, the Plan will pay 100% of those eligible expenses incurred during the remainder of that benefit year on behalf of such individual or family having met the aforementioned annual limit which would otherwise be eligible for 85% *(90% when care is received from a Select Provider)* payment.

Notwithstanding the above, any remaining days in a Convalescent Nursing Unit after the initial 100-day period of confinement will

continue to be reimbursed at 85% *(90% when care is received from a Select Provider).*

(e) Overall Benefit Maximum

A lifetime maximum of $1,500,000 of benefits will be payable with respect to all charges incurred for all illnesses during the entire duration of coverage for any one covered individual.

2. Expenses Eligible For Benefits

(a) Hospital Expenses

(1) General

Charges for hospital confinement due to an accident or sickness which is approved by a doctor licensed to practice medicine will be considered eligible expenses. In no event however, will benefits be paid for rehabilitation treatment of drug addicts or alcoholics in a hospital, in a wing or section of a hospital or in a facility connected with a hospital.

(2) Categories of Eligible Expenses

Benefits are provided for the following eligible charges:

(i) For semi-private accommodations, the eligible charges will be equal to the hospital's daily charge for room and board for a semi-private room.

For private accommodations eligible charges will be based on the hospital's average daily charge for room and board for a semi-private room.

Charges for room and board benefits will be eligible for reimbursement without any limit as to the maximum number of days except confinements for mental illness or functional nervous disorders of any type or cause will be limited to a maximum of 730 days for any one confinement. There will be no limit as to the number of these confinements for which benefits are paid if the confinements are due to a different cause or if separated by complete recovery.

This provision includes maternity benefits for female employees and wives of employees.

(ii) When there is a hospital charge for room and board, the following items will also be eligible for reimbursement: Miscellaneous hospital-medical services and supplies, administration of anesthesia, ambulance service provided by any hospital or professional ambulance service and charges made by hospital-approved physicians or other medical technicians for services utilizing hospital equipment, when

such services are not provided by the hospital or performed by members of the hospital staff.

The term "miscellaneous hospital-medical services and supplies" shall include bandages, crutches, splints, braces and trusses (including services related to initial fitting and adjustment of these items) when provided by the hospital or other professional qualified personnel.

The term "miscellaneous hospital-medical services and supplies" shall also include hospital charges for "supplementary medical service", "room and board supplement", "special room supplement", "isolation", "contagious", "intensive care", "cardiac care unit", or similar terms of like meaning if such services are, in fact, so billed and certified by the hospital to be hospital-medical services and/or hospital-medical supplies.

(iii) Charges for visits during a hospital confinement by a doctor licensed to practice medicine will be considered eligible expenses.

(3) Hospital Admission Certification Provisions

Whenever benefits are provided in accordance with subparagraphs (1) or (2) above, the amount of any such benefit payable will be subject to

hospital admission certification approval by the Utilization Review Firm. Certification approval by the Utilization Review Firm will be required as follows:

(i) Non-emergency medical or surgical admission will require Pre-Admission Certification as to the need for confinement.

(ii) Emergency admission will require notification to the Utilization Review Firm within 48 hours after the admission (or if longer, on the first business day following a weekend or holiday admission) and certification approval as to length of stay. When an emergency admission confinement does not exceed 48 hours, certification approval by the Utilization Review Firm will not be required.

(iii) Certification approval of hospital confinement admission will require concurrent review certification as to the continued need for confinement and length of stay.

(iv) Pre-Admission Testing (PAT) under an approved PAT program at the hospital in which surgery is to be performed will be required on all non-emergency surgery.

When certification is required and the Utilization Review Firm does not grant such certification approval, the benefits otherwise payable in subparagraphs (1) and (2) above, will be provided as follows:

(i) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for the weekend days of Friday or Saturday when a non-emergency admission occurs on such days unless surgery was performed on such weekend days of Friday, Saturday or Sunday or it was medically necessary for the patient to be admitted on the weekend days of Friday or Saturday.

(ii) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for the days of any admission where required certification was not obtained.

(iii) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for any days following the initial certification of a specified number of days for which certification approval was not obtained.

(iv) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charge for room and board for the first certified day of confinement when an approved Pre-Admission Testing (PAT) program was available at the hospital and such PAT was not used unless due to medical reasons.

The required certification approvals described in this subparagraph will be made by a Physician Advisor of the Utilization Review Firm following a review and evaluation of medical information provided by the patient's attending physician or by the Utilization Review Firm using established medical criteria to determine medical necessity and appropriateness of the admission and proposed plan of treatment. If the patient's attending physician and the Utilization Review Firm's Physician Advisor are unable to reach agreement concerning the patient's need for hospital confinement or continued confinement, the need for such confinement will be decided by a "local panel" physician.

(b) Post-Hospital Expenses

(1) Convalescent Nursing Unit Care

(i) Charges made by an approved Convalescent Nursing Unit for room and board and other services and supplies for medical care, exclusive of professional services, will be considered eligible expenses provided the Employee or dependent has been confined in a hospital for at least 3 days and then admitted to such Convalescent Nursing Unit within 21 days following the hospital confinement for the same condition that required hospital confinement and upon the written recommendation of the attending physician certifying

that the patient's condition would require continued hospital confinement if Convalescent Nursing Unit care were not available. Re-admission, upon the attending physician's recertification, to-such Convalescent Nursing Unit within 14 days following discharge will be considered a continuation of the same confinement for purposes of this Paragraph (a).

(ii) Eligible charges for all such services will be the charges actually made by the Convalescent Nursing Unit. Such allowance shall be paid only while the patient remains under the continuous care of the attending physician and only so long as the attending physician certifies that twenty-four hour a day nursing care is essential to the patient's health.

Convalescent Nursing Unit charges shall be eligible for reimbursement up to a maximum of 730 days of confinement in a Convalescent Nursing Unit reduced by the number of days of confinement in a hospital.

(iii) The term "Convalescent Nursing Unit" means a licensed institution approved by the Social Security Administration pursuant to Title XVIII (Health Insurance for the Aged) of the Social Security Act, as

amended in 1965. The term "Convalescent Nursing Unit" shall also include those institutions listed as "Extended Care Facilities" in the list titled "Accredited Extended Care Facilities" issued by the Joint Commission on Accreditation of Hospitals as it may be amended from time to time. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, or as a facility for the aged or for the care of drug addicts or alcoholics.

(2) Visiting Nurse Service

Charges will be considered eligible expenses for reimbursement when an employee or dependent receives medical treatment in his home by a Registered Nurse (RN) or a Licensed Physical Therapist employed regularly by an approved Visiting Nurse Service, immediately following and for the same cause which required a confinement in a hospital for at least 3 days, when ordered in writing by the attending physician.

The allowance for Visiting Nurse Service charges shall be the standard charge of the Visiting Nurse Service for each day such services are rendered to a maximum of 100 days for any one cause during any calendar year. Such allowance shall be paid only so long as the attending physician certifies such medical treatment to be necessary.

The term "Visiting Nurse Service", as used herein, means an organization or agency which meets all of the following requirements:

(i) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services,

(ii) Its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse to govern the services provided,

(iii) It provides for full-time supervision of such services by a registered nurse and has an administrator, and

(iv) It maintains a complete medical record on each patient.

(c) Outpatient Treatment And Diagnostic Expenses

(1) Charges directly connected with x-rays (except routine dental x-rays) or fluoroscopy for diagnostic purposes will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine, or a doctor of surgical chiropody.

Notwithstanding the above procedures done for diagnostic purposes in the event of accident or illness, charges will also be paid for:

(i) routine PAP test,

(ii) *routine mammogram performed annually upon the attainment of age 40.*

(2) Charges made for diagnostic laboratory tests will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine.

(3) Charges made for such medical tests as basal metabolism, electrocardiographs and electroencephalograms will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine.

(4) Charges made by a hospital for necessary medical care performed in the hospital's emergency or outpatient department for treatment of a physical disorder when authorized by a doctor licensed to practice medicine shall be eligible for reimbursement. Such medical care shall include all the hospital-medical services and supplies and other charges described in paragraph 2(a)(2)(ii).

(5) Charges made by a hospital will also be eligible for reimbursement when there is no hospital charge for room and board if the Employee or his dependent receives elector-shock therapy in a hospital or is confined in a hospital either for an operation or for emergency care following an accident (including removal, wherever performed, of sutures, clamps, or casts applied for treatment of injuries sustained in such accident).

(6) Other charges eligible for reimbursement will include:

(i) Charges made by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) for emergency care rendered in a medical facility (other than a hospital) or in a physician's office following an accident.

(ii) Charges made for a physician's services for medical care and treatment, surgery and acupuncture, excluding dental services.

(d) Surgical Expenses

(1) Surgical Services

Charges for surgical services consisting of operative and cutting procedures (including the usual post-operative care) arising from an accident or sickness not covered by a Workers' Compensation Act will be eligible for reimbursement. Such services may be performed in or out of a hospital by a doctor licensed to practice medicine. Other charges eligible for reimbursement will include:

(i) Surgical services performed by a doctor of surgical chiropody (D.S.C.) acting within the scope of his license, which are described in the Schedule of Surgical Operations—Chiropody (made a part hereof by reference).

(ii) Obstetrical services, including necessary prenatal and postnatal care, for pregnancies of female Employees and wives of Employees.

(iii) Non-operative procedures performed in lieu of surgery by a doctor licensed to practice medicine which are described in the "Schedule of Miscellaneous Specific Therapeutic Procedures" (made a part hereof by reference).

(iv) The administration of anesthetics, except local infiltration anesthetic, in connection with surgical or obstetrical services for which benefits are provided under the Program, when administered and billed by a doctor licensed to practice medicine, other than the operating surgeon or his assistant.

(v) When the surgical services are performed in a hospital, charges for the services of a doctor licensed to practice medicine who actively assists the operating surgeon in the performance of such surgical services when the type and complexity of the surgical services and the condition of the patient requires such assistance will be eligible for reimbursement.

(vi) Organ transplants when coordinated by the Network Administrator in

an approved network transplant facility. Benefits will be payable at 100% of the eligible charges and will not be subject to the deductible and co-payment provisions described in Paragraph 1. Organ donors will also be covered in the network when the recipient is covered for hospital, surgical and medical benefits under this Exhibit B-1. Reasonable travel and lodging expenses for the patient, the patient's spouse or family member and an eligible organ donor will be paid up to a total of $10,000.

If employees and eligible dependents do not have organ transplants coordinated by the Network Administrator in a network facility, benefits under this Exhibit B-1 will be limited to only eligible charges, subject to the deductible and co-payment provisions described in Paragraph 1, up to the amount that would have been paid if the transplant was done in a network facility. However, travel and lodging expenses will not be included or paid.

(2) Second Surgical Opinions

Charges made for a second surgical opinion in connection with a non-emergency surgical procedure will be eligible for reimbursement. A non-emergency surgical procedure is defined as a procedure

which may be scheduled at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

(e) Other Eligible Expenses

Charges actually made to the Employee or eligible dependent on account of their illness for service, treatment, and supplies ordered by a physician as described in this Paragraph (e) will be considered eligible expenses.

(1) Local ambulance service.

(2) Physician's services for medical care and treatment, surgery and acupuncture, excluding dental services.

(3) Private duty professional nursing services rendered by a registered nurse or a licensed practical nurse other than a close relative or a nurse who ordinarily resides in the Employee's home.

(4) Restoratory or rehabilatory speech therapy or speech therapy to correct speech impairment due to a structural, physiological or neurological disorder as certified by a physician, whether or not congenital, rendered by a qualified speech therapist for speech loss or impairment upon the written recommendation of a physician.

(5) Audiological testing services by an audiologist upon the written recommendation of a physician.

(6) The following other services, treatments and supplies:

Oxygen and rental of equipment for its administration.

Treatments by x-ray and by radium or other radioactive substances, including Psoralen longwave ultraviolet light (PUVA) treatment.

Treatments by a physiotherapist other than a close relative.

Surgical dressing.

Blood and blood plasma (unless replaced).

Artificial limbs, larynx and eyes.

Casts, splints, trusses, braces and crutches.

Preparation of casts, made of plaster and other synthetic molded materials, required for medical treatment.

Purchase or rental of wheelchair, hospital bed, iron lung and similar equipment provided in the case of purchase, that the criteria below have been fulfilled:

(i) the use of such equipment must be certified by the attending physician to be medically necessary.

(ii) the rental cost of the equipment for the period of use prescribed by the attending physician exceeds the purchase price.

Whenever the purchase price of the equipment exceeds $500, prior approval of the Company will be required.

(7) Charges incurred in connection with (i) mental illness or functional nervous disorders of any type or cause, or (ii) room and board and other services and supplies furnished by a Convalescent Nursing Home for medical care, exclusive of professional services (see additional provisions for Convalescent Nursing Home Benefits) will be considered eligible expenses.

(8) The first routine hospital visit to a newborn child by a physician.

3. Exclusions and Ineligible Expenses

Eligible expenses will not include any of the following:

(a) Charges incurred in the event of an accident or sickness covered by a Workers' Compensation Act or similar legislation.

(b) Charges for eye refractions or examinations for the fitting of glasses or hearing aids.

(c) Charges for medical examinations of a covered individual for "check-up" purposes when not incident and necessary to the treatment of an illness.

(d) Charges incurred in connection with remedying a condition by means of cosmetic surgery unless such condition is the result of accidental bodily injuries sustained while a covered individual.

(e) Charges incurred during confinement in a hospital owned or operated by the United States Government or any agency thereof, charges for services, treatments or supplies furnished by or for the United States Government or any agency thereof, and charges incurred during confinement in a hospital owned or operated by a State, Province or political subdivision unless there is an unconditional requirement to pay these last mentioned charges without regard to any rights against others, contractual or otherwise.

(f) Charges for physicians' services in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, including treatment for temporomandibular joint (TMJ) dysfunction.

(g) Charges for physicians' services in connection with weak, strained or flat foot, any instability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for an open cutting operation or for services prescribed by a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

(h) Charges for physicians' services in connection with corns, calluses or toenails; unless the charges are for the partial or complete removal of nail roots or for services prescribed by a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is treating the patient for a metabolic or peripheralvascular disease.

(i) Charges incurred for services, treatments and supplies in connection with an illness of a covered individual, to the extent to which such services, treatments and supplies, or payment of such charges, or any benefit for or in connection with such charges, services, treatments or supplies, is provided for the covered individual under or by any law or plan of any government or political subdivision, including Medicare, or any other plan which you participate by virtue of your employment with the Employer.

If, after benefits have been paid on account of services, treatments and supplies given to the Employee or eligible dependent in connection with an illness of such person, it is determined that any such services, treatments or supplies have been provided from any source referred to above, the Employer will be entitled to a refund from the Employee of the amount paid by it in connection with such illness which is in excess of the benefits which would have been payable based on the actual eligible charges incurred.

(j) Expenses incurred for private room accommodations which are in excess of the hospital's daily charge for a semi-private room.

(k) Services, supplies, and treatment prescribed by someone other than a physician.

(l) Services or supplies of common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, blood pressure kits, or supplies of a similar nature, even if prescribed by a physician.

(m) Custodial care, including accommodations, professional services, and nursing services needed only for daily living, not for the treatment of an illness or injury.

(n) Services or supplies for training or education, such as prenatal classes, diabetic training, etc., or for learning disabilities.

(o) Services provided by a member of your immediate family.

(p) Services or supplies provided by a sanitarium.

(q) Rest cures, travel, recreation or physician directed diversional therapy.

(r) Hospitalization for environmental change or charges connected with prescribing such a change.

(s) Private duty nursing for custodial purposes.

(t) Charges incurred for prescription drug expenses in excess of the Plan allowance.

(u) Research studies and screening exams.

(v) Respiratory/inhalation therapy in an outpatient facility unless performed as part of the treatment for an accident, illness, or surgery resulting from an emergency.

(w) Services or supplies used to treat conditions related to autism, hyperkinetic syndromes, learning disabilities, discipline problems or mental retardation, except to diagnose the condition.

(x) Sterilization reversals.

(y) Certain services related to obesity and weight loss.

(z) Nursing care associated with an inpatient stay, nor billed as regular room and board charges.

(aa) Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

(bb) Any service or supply not covered in this Plan.

(cc) Care and supplies related to:

—artificial insemination;

—sex change operations;

—sterilization reversal;

—fertility treatment;

—immunizations.

(dd) Charges which an Employee is not legally required to pay.

(ee) Charges which exceed reasonable and customary charges.

(ff) Charges which would not have been made if an Employee had no insurance.

(gg) Charges for care, treatment, or surgery that is not medically necessary.

(hh) Charges which would have otherwise been considered eligible and which were not paid because the Employee or dependent did not follow the required procedures for:

—Pre-admission certification

—Concurrent review after admission

(ii) Services or supplies for experimental procedures or treatment methods.

(jj) Certain services related to the correction of refractive error.

4. Chiropractic Expenses

The Employer will provide the following benefits for chiropractic services for eligible Employees and their dependents.

(a) Charges for chiropractic services of manipulation or adjustment for the treatment of non-occupational neuromusculoskeletal conditions which are performed by and during a

visit to a duly licensed Chiropractor (D.C.) or a Doctor of Osteopathy (D.O.) practicing within the scope of their license, subject to a maximum of 30 visits per calendar year per individual will be considered eligible expenses.

(b) Charges incurred for x-rays made during any such visit when necessary for the diagnosis and analysis of such neuromusculoskeletal condition will be considered eligible expenses for reimbursement. The maximum benefit for all such x-rays arising out of the same condition will be $100 for each Employee or dependent of an Employee during a calendar year.

5. Prescription Drug Benefits

(a) General

Prescription drug payments will be made if an Employee or Dependent, as a result of an accident or sickness, incurs expenses for covered prescription drugs dispensed by any person or organization legally licensed to dispense drugs, upon the order of a physician licensed to practice medicine.

(b) Benefits

(1) Benefits will be provided through participating providers who have agreed to accept an assignment of the benefit claim hereunder by the Employee to the provider plus a co-payment by the Employee or Dependent of *$4.00* for generic medication or $10.00 for name brand drugs as

full payment for the covered prescription drug. The co-payment amount herein is to be paid by the Employee or his Dependent and is applicable to each separate prescription order and to each refill thereof.

(2) Maintenance drug requirements may be filled through the Mail-Order Prescription Service established by the Company *in which case the co-payments contained in paragraph (b)(1) above will be reduced to $2.00. If a physician authorizes a generic medication to be dispensed and the patient insists on a name brand drug, the reimbursement under the Mail-Order Prescription Service shall be limited to the amount payable as if the generic drug had been dispensed.*

(3) If a covered prescription drug is dispensed by a non-participating provider, the amount of the benefit for each separate prescription order and each refill thereof will be:

(i) The dispensing fee for the covered prescription drug which the individual provider most frequently charges his customers for dispensing similar drugs, plus

(ii) the actual cost of the covered prescription drug to the provider, plus

(iii) any applicable state sales tax for the covered prescription drug, less

(iv) $4.00 for generic medication or $10.00 for name brand drugs.

(4) If a prescription is filled outside of the Mail-Order Prescription Service and if a name brand drug is dispensed in lieu of a generic equivalent drug which has been approved for inclusion in the Maximum Allowable Cost (MAC) list by the Network Administrator, the reimbursement will be limited to the amount payable as if the generic drug had been dispensed.

(c) Covered Prescription Drugs

The prescription drugs covered by this paragraph are

(1) Injectable insulin, or any Prescription Legend Drug for which a prescription is required;

(2) A compound medication of which at least one ingredient is a Prescription Drug; and

(3) Any other drug which under the applicable state law may be dispensed only upon the prescription of a physician:

Provided that a prescription drug shall not be covered under this Paragraph if (i) the cost thereof is included in the cost of other services or supplies provided to or prescribed for the Employee or his dependent or (ii) such drug is consumed at the time and place the prescription is ordered; except, however, a drug

dispensed by a licensed pharmacy doing business with the public will be covered.

"Prescription Legend Drug" means for the purpose of this Paragraph, any medical substance, the label of which, under the Federal Food, Drug, and Cosmetic Act, as from time to time amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription".

(d) Exclusions

(1) No benefit shall be payable to an Employee or his Dependent if he is entitled to receive reimbursement under any Workers' Compensation Laws or is entitled to benefits from any municipal, state, federal or other governmental program of any sort.

(2) No benefit shall be payable for any medication or device which is to be used for contraceptive purposes, or for any therapeutic device or appliance (e.g., hypodermic needles, syringes, support garments and other non-medicinal substances).

(3) No benefit shall be payable for the administration of any medication.

(4) When a prescription drug is dispensed through a participating provider, no benefit shall be payable for any medication for which the customary and usual charge is less than *$4.00* for generic

medication or $10.00 for name brand drugs.

*

(5) No benefit shall be payable for more than a 100-day supply of any medication *through the Mail-Order Prescription Service (30-day supply Service)*, for any refill in excess of the number specified by the physician, or for any refill dispensed after one year from the physician's order.

(6) No benefit shall be payable for any drug defined in paragraph (c) above, the reimbursement for which is considered taxable income by the Internal Revenue Service.

(e) In addition to the benefits otherwise provided, herein, the Company may make available to Employees a mail order option.

(f) The eligible charges payable herein by the Employee will not be included for purposes of meeting the deductible nor will they apply towards the co-payment maximum.

6. Eligibility for Benefits under Exhibit B-1

(a) Active Employees who have elected the benefits provided under Exhibit B, will be covered by the provisions of this Exhibit B-1 on that Effective Date. Employees not actively at work on the Effective Date, will be covered by the provisions of this Exhibit B-1 immediately upon their return to work, but until

such return to work, will have such coverage for hospital expense, surgical, hospital-medical and prescription drug benefits, if any, and for such period of time as is provided for them in the plan in effect prior to the Effective Date.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

(b) Employees hired after the Effective Date who elect the benefits provided under Exhibit B-1, will become covered by the provisions of this Exhibit B-1 on the 31st day of employment.

(c) Coverage for an Employee's dependents will become effective on the same date as the Employee's coverage except that if a dependent, other than a new-born baby or a child placed for adoption with the Employee, of an Employee hired after the Effective Date, is confined in a hospital when the coverage for that dependent would otherwise become effective, the coverage will become effective upon final discharge from the hospital.

(d) An Employee's dependents are:

(i) The spouse, and unmarried children of the Employee under 19 years of age. A spouse becomes an Employee's dependent on the date of marriage to the

Employee. An unmarried child becomes an Employee's dependent on the later of:

the child's date of birth, or

the date of the Employee's marriage, in the case of a child acquired by marriage, or

the date of adoption of the child, or, if earlier, the date the child is placed with the Employee for adoption and the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Eligibility as a dependent for a child placed with the Employee for adoption terminates upon the termination of the legal obligation of the Employee for total or partial support of the child.

(ii) Unmarried children of the Employee who are eligible as dependents may continue to be deemed eligible dependents of the Employee beyond age 19 provided such children upon attainment of age 19 are both dependent upon the Employee, as determined by the Employer, and are either:

mentally or physically incapable of self support, or

full-time students at an accredited high school, college or similar institution of higher education in a course of study

leading to a high school diploma, an Associate degree, a Bachelor's degree or a higher degree.

Extended eligibility as a dependent beyond age 19 will terminate when the Employee's child is:

no longer mentally or physically incapable of self-support as a result of the disability which gave rise to the original extension of coverage, or no longer a full-time student, or attains age 27, if earlier. In the case of a full-time student, the child who attains age 19 or ceases to be a full-time student, may again be deemed to be an' eligible dependent as a full-time student if the child otherwise meets the requirements of this Paragraph (d)(ii) and, within 24 months following the date the child ceased to be a full-time student, requalifies as a full-time student.

Eligibility will also be extended to a child who was covered as a full-time student following the attainment of age 19 and while covered as a full-time student becomes disabled as herein defined. However, such eligibility will not be extended beyond the attainment of age 27.

(iii) The donor of an organ for transplant, when the recipient is covered for hospital, surgical, and medical benefits under this Exhibit B-1 shall also be covered for such benefits as though the donor were a covered dependent

child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor.

The word "child" in addition to the Employee's own children includes such stepchildren, foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, placement for adoption, or marriage, such dependent shall not become eligible until three months have elapsed from the date such child was added to the Employee's enrollment record.

The term "unmarried children" means children who have never been married. When a dependent child becomes married, even though the marriage may later be dissolved, such child ceases to be an eligible dependent, forever.

7. Layoff

(a) In the event of layoff, coverage under this exhibit B-1 will be continue[d] without cost to the Employee for 90 days following layoff.

(b) Thereafter, coverage will be continued without cost to the Employee for a period during which he is laid off for one of the reasons set forth in Article I, Section 4(a) of the Shell Supplemental Unemployment Benefits Plan maintained by the parties hereto under Agreement as amended on April 26, 1973 and with respect to which he receives no

earnings for work performed for the Employer; but the maximum period of such continued coverage shall be determined in accordance with the following table:

Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him	Maximum Number of Months for which the Comprehensive Medical Benefits Plan Coverage will be Continued Without Cost to Employee
16-19	1
20-23	2
24-27	3
28-31	4
32-35	5
36-39	6
40-43	7
44-47	8
48-52	9

(i) In applying the above table, the "Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him" shall be determined by dividing the number of the Employee's Credit Units under the Supplemental Unemployment Benefits Plan by the number of Credit Units to be cancelled for one SUB Benefit in accordance with the Credit Unit Cancellation table continued in Article III, Section 4 of such Supplemental Unemployment Benefits Plan, based on the Employee's seniority and the Trust Fund Position in effect as of the last

day worked prior to layoff. The "Maximum Number of Months for Which the Comprehensive Medical Benefits Plan Coverage will be Continued Without Cost to Employee" shall commence with the 91st day of layoff.

(ii) With respect to any period of continuous layoff, changes in an Employee's Credit Units, Seniority or Trust Fund Position subsequent to the date layoff begins shall not change the number of months of continued coverage for which such Employee is eligible.

(iii) In the event that the aforesaid Shell Supplemental Unemployment Benefits Plan shall be terminated in accordance with its terms prior to the termination of the Agreement, Subparagraph (b) of this Paragraph 7 shall thereupon cease to have any force or effect.

(iv) The foregoing provisions of the Subparagraph (b) shall be subject to the Employer obtaining and retaining from the Commissioner of Internal Revenue and from the United States Department of Labor the rulings referred to in the Agreement between the parties of April 26, 1973 relating to Supplemental Unemployment Benefits, and shall be effective with respect to layoffs commencing on or after the first day of the month following the month in which such rulings are received by the Employer. Pending receipt of said rulings, the foregoing provisions of this Subparagraph (b) will

nevertheless be made operative as to any Employee for a period up to 90 days.

(c) The maximum period of coverage under this Paragraph 7 shall be 24 consecutive months following the month in which the Employee was laid off. For any month in this period not covered by Employer-furnished coverage, the Employee may continue the coverage by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage.

(d) An Employee on layoff may not continue coverage as provided in Subparagraphs (b) or (c) above while covered by any other employer-furnished hospital, medical and surgical benefit program; however, when the Employee ceases to be covered by any such other program, the Employee may then resume coverage hereunder for the remainder of the 24-month maximum period. In order to remain eligible for continued coverage as provided in Subparagraphs (b) and (c) above, the Employee must maintain such coverage continuously except as provided above in this Subparagraph (d).

(e) Employees re-employed with credit for prior service will have an immediate reinstatement of coverage.

(f) An Employee on layoff eligible for coverage under this Paragraph 7 upon acceptance of any benefit payable under Article XIII of the 1950 Pension Plan shall be deemed to have terminated his employment with the

Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this Paragraph 7.

8. Leave of Absence, Etc.

(a) During authorized leave of absence, (Other than leaves for which coverage is provided in Subparagraphs (b), (c) and (d) below), coverage under this Exhibit B-1 will be continued for a period not to exceed 90 days. Employees on leave of absence extending beyond such 90-day period may, by application to the Employer during such period and advance payment of current group rate premium, continue such coverage during the period of such leave of absence. An Employee who leaves the employ of the Employer as the result of being elected or appointed to public office or to an office in a Local Union cooperative enterprise serving Company employees may, by application to the Employer prior to leaving his employment with the Employer and upon advance payment of the current group rate premium, continue such coverage during the period of his service in such office.

(b) During an authorized leave of absence for active duty in the Armed Forces for a period of less than six months, an Employee (and his eligible dependents) shall continue to be eligible for the benefits provided in this Exhibit B-1 to the extent that such benefits are not provided by the Military Service or the Federal or State Government.

(c) During an authorized leave of absence for pregnancy, Employees (and their eligible dependents) will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

(d) Notwithstanding the foregoing, coverage shall be continued without cost to the Employee during the period of an Employee's authorized leave of absence granted by his Employer for service with a local Union in an official or representative capacity or while representing such local Union in a State, County, or City council of AFL-CIO-CLC.

9. Injury or Sickness

Employees off work due to injury or sickness will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

10. Termination of Coverage Under Exhibit B-1.

Except as described in Paragraphs 7, 8 and 9 immediately above, all coverage will terminate when active employment with the Employer terminates except as follows:

(a) The hospital, surgical, hospital-medical and prescription drug benefits for an Employee or dependent will be extended for three months following termination of coverage to cover a hospital confinement, an operation or obstetrical procedure resulting from a continuous total disability which began while the coverage was in force.

(b) Coverage will be extended for six months for the spouse and dependent children of an Employee who dies while on the payroll of the Employer, while on sick leave (and accumulating seniority), while on layoff with Exhibit B-1 coverage provided continuously under Paragraph 7 of this Exhibit B-1, during authorized leave of absence for a period not to exceed 90 days, or while on authorized leave of absence for service with a Local Union in an official or representative capacity.

The surviving spouse of a deceased Employee who is not eligible for continued coverage under Paragraph 12(b) of this Exhibit B-1 may elect, within such six months, to extend such coverage for up to an additional 18 months by payment in advance of the current group rate premium. Such spouse may make arrangements for the premium to be paid (i) in a lump sum amount equal to 14 monthly payments which may be deducted from any benefits the spouse is entitled to receive under Section A, Life Insurance or (ii) in quarterly installments paid directly to the Company.

(c) Coverage for an unmarried full-time student will be extended for 90 days following termination of status as full-time student provided no other group medical coverage of any kind is in effect on such student.

(d) Where practicable the Employer will arrange with an insurance company for issuance of individual policies of medical expense

benefits without medical examination when elected by an individual whose coverage terminates as provided in Paragraphs 7, 8, 9 and this Paragraph 10 or with respect to a child who no longer meets the eligibility requirements of this Exhibit B-1. Issuance of such an individual policy will be subject to the following:

(i) the Employee has been covered for 3 or more months under Exhibit B-1, and

(ii) a written application and payment of the first 3 months premium is made within 31 days following termination of coverage under Exhibit B-1, and

(iii) the individual policy will be one of the policies issued by the insurance company for conversion purposes and subject to the terms and conditions of said policy.

11. Employees Retired on Pension

*

*Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan *(other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1993 Pension Plan)* whose full years of attained age and full years of attained continuous service *(as defined in Article I of the 1993 Pension Plan)* at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of the benefits described in this

Exhibit B-1; *provided, however, that each Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.* An Employee earns one point for each year of attained age and one point for each year of attained continuous service. Total points are derived by adding together the attained age and attained continuous service points. Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the benefits described in this Exhibit B-1. Failure to pay the required medical contribution will result in cancellation of coverage.

An Employee who retires with thirty (30) or more years of *continuous* service at any age will receive 95 points at retirement.

An Employee who retires with a disability Pension with ten (10) or more years of *continuous* service will receive an additional 30 points at retirement.

An Employee who does not preferentially hire and subsequently retires as a result of a plant closure will receive an additional *25* points at retirement.

An Employee who, on January 1, 1996 is:

(a) Age 50 or older and has 10 or more years of continuous service but less than 30; or

(b) Any age and has 20 or more years of *continuous* service but less than 30;

will receive an additional 15 points which will be added to the Employee's point total at the time of their retirement.

After the date of the Employee's retirement, the deductible of this Exhibit B-1 shall be limited to *$175* per person, *$350* per family and the co-payment maximum shall be limited to $500 a year.

As an alternative to the above, an Employee required to make the described health care contribution may elect; at the time of retirement, a catastrophic medical plan option based on the benefits described in this Exhibit B-1. The deductible under this option shall be $1,000 per covered Individual per year, $2,000 per family per year, 80% Company co-payment, 20% retiree co-payment and a retiree co-payment maximum (after the deductible is satisfied) of $1,000 per covered individual or $1,500 per family per year. There is no health care contribution required for this option.

A retired employee required to make a health care contribution as described above shall be afforded the opportunity to change his medical plan option election in the event there is a change in the amount of the retiree medical

contribution required or there is a change in the plan design.

12. Survivor Benefits

(a) The surviving spouse of (i) a deceased Employee who retires on or after the Effective Date, and was eligible for and receiving a monthly pension (other than a deferred vested pension or any benefit under Articles XI, XII or XIII of the 1993 Pension Plan), and (ii) a former Employee whose employment was terminated on or after the Effective Date, at or after attainment of age 60 and who dies after he has commenced to receive a deferred vested pension, shall be entitled to continue to receive the benefits of this Exhibit B-1 until death or remarriage under the exact same conditions and amounts that such surviving spouse was entitled to such benefits as a dependent immediately prior to the death of such deceased former Employee, provided such surviving spouse was either an eligible spouse at the time of the Employee's retirement or had been legally married to the Employee for at least 12 consecutive months preceding his death.

Also, the surviving dependent of an Employee who is retired by the Employer and receiving a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1993 Pension Plan) on or after the Effective Date, provided such dependent as of the date of the death of such retired Employee was covered by these

benefits as an eligible dependent, shall continue to be eligible to receive the exact same benefits and under the same conditions. Such coverage shall terminate when the surviving spouse remarries, provided further that such coverage shall continue after the death of spouse (if spouse has not remarried), so long as the dependent continues to qualify as such (but for being dependent on the Employee) and provided such surviving dependent was either an eligible dependent at the time of the Employee's retirement or was also a dependent of a surviving spouse who had been legally married to the Employee for at least 12 consecutive months preceding his death.

(b) The benefits provided under this Exhibit B-1 shall continue for the spouse and dependents of an Employee who had (i) attained age 55 or more and had 10 or more years of continuous service or (ii) 20 or more years of continuous service, and who dies and at the date of death was eligible for said benefits, was on the payroll of the Employer, was on sick leave (and accumulating seniority), was on layoff with Exhibit B1 coverage provided continuously under Paragraph 7 of this Exhibit B-1, was on authorized leave of absence for period not to exceed 90 days, or was on authorized leave of absence for service with a Local Union in an official or representative capacity. Such coverage shall terminate when spouse remarries or dies; provided that such coverage for each dependent shall continue after the death of the spouse (if the

spouse has not remarried) so long as the dependent continues to qualify as such (but for being dependent on the Employee) under (i) or (ii) of Paragraph 6(d) of this Exhibit B-1.

In the event there is no surviving spouse as described above, such coverage shall also continue for a surviving dependent provided such surviving dependent was an eligible dependent at the time of the Employee's death and continues to qualify as such (but for being dependent on the Employee) under (1) or (ii) of Paragraph 6(d) of this Exhibit B-1.

13. Special Medicare Benefit

(a) Eligibility for Benefit

An Employee, Pensioner or eligible Surviving Spouse, and their eligible dependents, who are eligible for benefits under this Exhibit B-1 will be eligible for a Special Medicare Benefit upon (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, when first eligible to enroll in Part B of Medicare with Medicare as primary coverage, provided the individual enrolls and continues to be enrolled in Part B of Medicare.

(b) Amount of Benefit

The amount of the Special Medicare Benefit will be equal to the lesser of the standard monthly premium for Part B of Medicare or $*50.00* that is paid by persons who enroll when first eligible for primary Medicare

coverage but shall not include any additional premiums such as those charged for delinquent enrollment.

Notwithstanding the above, the Special Medicare Benefit for any person who enrolls and continues to be enrolled in a Medicare Risk HMO under the provisions of Exhibit B-1, Paragraph 15 will be equal to the standard monthly premium for Part B of Medicare.

(c) Payment of Benefit

The Special Medicare Benefit will be paid to the Employee, Pensioner or eligible Surviving Spouse. Payment of the Special Medicare Benefit will commence on the first day of the month following (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, the first day of the month following the month for which such individual is eligible to enroll in Part B of Medicare with Medicare as primary coverage, provided the individual enrolls in Part B of Medicare.

Payment of the Special Medicare Benefit shall continue so long as the Employee, Pensioner or eligible Surviving Spouse and the eligible dependents continue to be covered for benefits under this Exhibit B-1 and continue to be enrolled for coverage under Part B of Medicare.

The Special Medicare Benefit will not be paid for any eligible dependent who is also

eligible for this Special Medicare Benefit as an Employee, Pensioner or Surviving Spouse or when such dependent is reimbursed by another employer for the Medicare Part B premium. When a dependent child is covered by this Paragraph under more than one Employee or Pensioner, the Special Medicare Benefit will be paid only to the male Employee or Pensioner.

* * *

24. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 24 is provided in lieu of all other coverage under Part V Section A of the Agreement and this Exhibit B-1. However, upon termination of coverage under this Paragraph 24, the conversion privileges of Part V Section A, Paragraph 1 of the Agreement and Exhibit B-1, Paragraph 10(d) and the termination provisions of Exhibit B-1, Paragraph 10 shall apply.

Coverage under Part V Section A of the Agreement will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of Section A. Coverage under Exhibit B-1 will be extended following such Plant Closure without cost to the Employee for an additional 12 months beyond Employer-furnished coverages provided in Paragraph 7 of Exhibit B-1. However, in no event shall the coverage provided in Paragraph 7(b) of Exhibit B-1 be less than 9 months. For

any month in which Employer-furnished coverage is provided under Paragraph 1 Part V, Section A of the Agreement, the Employee may continue to purchase coverage under Paragraph 2 of Section A.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Shell Supplemental Unemployment Benefits Plan, coverage under Exhibit B-1 may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 24 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 and 36 consecutive months for coverage under Exhibit B-1 following the month in which such Plant Closure occurred.

Coverage under this Paragraph 24 will not continue as provided above while the Employee is covered by any other employer-sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 24.

* * *

LETTER #20

May 9, 199[7]

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

Reference is made to the Medical Necessity Benefits Program, Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions as provided in the Supplemental Pension, Insurance and Service Award Agreement dated July 20, 1994 as well as the Comprehensive Medical Benefits Program and Employee Savings Plan For Bargaining Unit Employees, as provided in the Pension, Insurance and Service Award Agreement dated July 20, 1994.

It is hereby agreed that from May 9, 1997 to August 1, 1997, the Medical Necessity Benefits Program, Major Medical Benefits Program for Employees and their Dependents and Employee Savings Plan Without Matching Contributions * will continue to be provided under the Supplemental Pension, Insurance and Service Award Agreement dated July 20, 1994.

Employees who are covered to August 1, 1997 by the Medical Necessity Benefits Program, Major Medical Benefits Program and Employee Savings Plan Without Matching Contributions will be advised in writing of their transition to the Comprehensive Medical Benefits Program (Exhibit B-1) and Employee

Savings Plan For Bargaining Unit Employees (Exhibit B-2), including a summary of the Comprehensive Medical Benefits Program. An employee currently enrolled in the Employee Savings Plan Without Matching Contributions will be automatically enrolled in the Employee Savings Plan for Bargaining Unit Employees. Any changes in contribution percentage made by July 15, 1997 by Employees who are participating in the Employee Savings Plan Without Matching Contributions will be effective August 1, 1997 and will apply to the Employee Savings Plan for Bargaining Unit Employees.

Also it is agreed that Employees who retire prior to August 1, 1997 who are enrolled in the Medical Necessity Benefits Program and Major Medical Benefits Program for Employees and their Dependents shall be afforded the opportunity to elect the Comprehensive Medical Benefits Program for Employees and their Dependents with coverage to be effective on the date of their retirement.

Employees who have satisfied all or part of the deductibles under the Major Medical Benefits Program for 1997 will have these fully or partially satisfied deductibles applied to the deductibles in the Comprehensive Medical Benefits Program on the dates set forth above.

It is hereby agreed that from May 9, 1997 through December 31, 1997 the Comprehensive Medical Benefits Program for Employees and their Dependents and Employee Savings Plan for Bargaining Unit

Employees will continue to be provided under the Pension, Insurance and Service Award Agreement dated July 20, 1994.

Sincerely,

/s/ JM Warren

Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H. Davis
Richard H. Davis

(Original letter dated May 2, 1985
from F R Tully to Stanley Somo)

AGREEMENT

Between

Shell Chemical Company
Point Pleasant Polyester Plant

and

Local Union 644

of the

United Steelworkers of America,
AFL-CIO-CLC

Effective November 6, 1997

* * *

ARTICLE XV
EFFECTIVE DATE AND TERMINATION

SECTION 1

This Agreement shall become effective November 6, 1997 and shall continue in effect until 12:01 a.m. November 6, 2000. Thereafter it shall renew itself for yearly periods unless written notice is given by either party to the other not less than sixty (60) days but not more than seventy-five (75) days prior to the expiration date or any extension thereof that is desired to terminate or amend the Agreement. In the event such notice is given, the parties shall begin negotiations within forty-five (45) days prior to 12:01 a.m. November 6, 2000. At the opening of such negotiations both parties shall present to each other in writing their proposed changes in said Agreement. If negotiations are not completed prior to the expiration

date, this Agreement shall terminate unless extended by mutual agreement of the parties.

SECTION 2

In the event that right, title or possession to the plant covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale or any other method of disposition or acquisition, this Agreement shall be binding upon the Company and its successors and assigns.

* * *

LETTERS OF INTENT

Letter A

November 6, 1997

Mr. WS (Scott) Blas
President, USWA, Local 644

Dear Mr. Blas:

This Company and the Union agree that for the duration of our Articles of Agreement which continue in effect until 12:01 a.m., November 6, 2000, the benefit plans currently applicable to employees you represent at the Point Pleasant Polyester Plant will be continued, subject to the changes shown in the attachments.

The parties agree to implement these changes to benefit plans on the date shown even if such

effective dates fall beyond the terms of our next Agreement, provided the benefit plan affected is applicable to union represented employees at that time.

Sincerely,

W. O. Wunder
Manager Human Resources

BUCK
CONSULTANTS
One Mellon Bank Center
500 Grant Street, Suite 2900
Pittsburgh, Pennsylvania 15219-2513

December 16, 1999

Mr. Aly Kenji
Meynor Limited
1 Egerton Place
London SW3 2EF
United Kingdom

Re: Project Sunkist

Dear Aly:

We have completed our analysis of the pension and postretirement benefits for both hourly and salaried employees of the PET division of the ABC Company.

Our report presents:

- A restatement of the results as reported by the ABC Company, along with a summary of the data and assumptions used to determine these numbers.
- Our estimate of the results based on the information provided to us.
- Our comments on the results.
- An explanation of possible changes in the results due to changes in the workforce.

If there are any questions regarding the contents of this letter, please feel free to call.

Sincerely,

David R. Jarrett
Consulting Actuary

Duane Lee
Consulting Actuary

DRJ:DL:ART
Enc.

Exhibit I
PET Business
Summary of Pension Liabilities
as of December 31, 1999
($ Millions)

Pt. Pleasant Hourly		
	Interest Rate	
	6.5%	7.5%
Accumulated Benefit Obligation	$ 40.9	$ 36.6
Projected Benefit Obligation	40.9	36.6
Market Value of Assets	27.6	27.6

PET Salaried Spin-Off		
	Interest Rate	
	6.5%	7.5%
Accumulated Benefit Obligation	$ 6.1	$ 5.2
Projected Benefit Obligation	8.6	7.2
Assets (based on 7.5% transfer)	7.2	7.2

Definitions:

Accumulated Benefit Obligation (ABO): The liability for benefits based on service and salaries as of the determination date. This is the liability for the plan if benefits were to be frozen.

Projected Benefit Obligation (PBO): The liability for benefits based on service at determination date and salaries projected to termination/retirement. Same as the ABO, except with projected salaries. For non-salary-related plans, such as Pt. Pleasant Hourly, the ABO and PBO are equal.

Exhibit II
PET Business
Discussion of Pension Liabilities

- Plan participants on which liabilities are based were provided by FBD Consulting (Pt. Pleasant Hourly) and Buck Consultants – Houston, TX (PET Salaried). Data was gathered in early November 1999. The participants are summarized below:

	Pt. Pleasant Hourly	PET Salaried
Active	282	151
Terminated with Vested Benefits	368	0
Retirees	305	0
Total	955	151

- Plan assets for Pt. Pleasant Hourly are equal to the market value of assets as provided by FBD Consulting as of November 30, 1999.
- Plan assets for PET Salaried were set equal to the Projected Benefit Obligation calculated at 7.5%. Actual assets will be determined as of the date of the spin-off.
- For the PET Salaried Plan, compensation for participants is assumed to increase on average at 5.5% per year.

Exhibit III
PET Business
Summary of OPEB Liabilities
as of December 31, 1999
($ Millions)

Pt. Pleasant Hourly		
	Interest Rate	
	6.5%	7.5%
Accumulated Postretirement Benefit Obligation:		
Actives	$ 8.7	$ 6.8
Retirees	18.5	17.0
Total	$ 27.2	$ 23.8

PET Salaried Spin-Off		
	Interest Rate	
	6.5%	7.5%
Accumulated Postretirement Benefit Obligation:		
Actives	$ 3.1	$ 2.5
Retirees	0	0
Total	$ 3.1	$ 2.5

Definitions:

Accumulated Postretirement Benefit Obligation (APBO): The liability for benefits based on service as of the determination date.

Exhibit IV
PET Business
Discussion of OPEB Liabilities

- Due to time constraints, a detailed actuarial valuation of postretirement medical liabilities was not performed.
- Results as determined by PricewaterhouseCoopers were provided to us along with a summary of the actuarial assumptions.
- A review of the results was made to check for reasonableness based on the information provided.
- These reported liabilities were adjusted to reflect different assumptions which we deemed to be appropriate. In particular, the liabilities were

adjusted to recognize a more reasonable medical trend rate. These liabilities were also adjusted to December 31, 1999.

- Information identifying the approximately 70 employees to be terminated at the Pt. Pleasant location is unavailable because the program will be offered to all employees on a voluntary basis.
- While we do not have any actuarial experience to compare, the demographic assumptions do not appear to be unreasonable.
- For comparison purposes, we have shown our estimate of the FAS No. 106 liabilities based on a 6.5% and 7.5% discount rate.
- These numbers assume the active population continues to be actively employed.
- A medical trend rate of 8.5% grading down to 5.0% is assumed.

Exhibit V
PET Business
Impact of Employee Reductions of Pensions

- Information identifying the approximately 70 employees to be terminated at the Pt. Pleasant location is unavailable because the program will be offered to all employees on a voluntary basis.
- In order to estimate the impact of reducing different segments of the Hourly Pt. Pleasant workforce, we have estimated the change in Projected Benefit Obligation from terminating the oldest 70 employees, the youngest 70 employees, and a mixture of the two.

	Oldest 70	Youngest 70	Mixed 70
Change in Projected Benefit Obligation			
at 6.5%	$ 2.3	$ (0.3)	$ (0.8)
at 7.5%	2.2	(0.2)	(0.7)

- We have also estimated the impact on the Projected Benefit Obligation of terminating 50 hourly employees at Pt. Pleasant.

	Oldest 70	Youngest 70	Mixed 70
Change in Projected Benefit Obligation			
at 6.5%	$ 2.1	$ (0.2)	$ (0.5)
at 7.5%	2.0	(0.2)	(0.5)

- Although reductions in Pt. Pleasant Salaried employees will change the gross benefit liability, the net benefit liability (PBO less assets) should remain unchanged. Since the terminations are expected to occur before the spin-off of assets, any change in gross liability will result in the same change to assets that are spun-off to the Plan.

- If all but 17 Akron salaried employees remain participants in their current program, gross benefit liabilities will be reduced significantly. Net benefit liabilities should remain unchanged, however, since the assets transferred as part of the spin-off will also be reduced by the same amount that liabilities are reduced.

Exhibit VI
PET Business
Impact of Employee Reductions of OPEB

- A reduction of 70 Pt. Pleasant active employees may increase or decrease the liability depending on the demographics of the group.

  There is a significant cost of providing medical benefits for employees who are eligible for benefits. However, there is an offsetting credit for employees who are not eligible for benefits.

  If the group consists of a large number of employees who are eligible for benefits, then an increase in liability would result. However, if the group consists of young, short-service employees, then a decrease in liability is likely. The most probable scenario is that the two will offset each other.

- The salaried results include 60 Akron employees. If ABC Company retains 43 of these employees, the liabilities shown will be decreased accordingly. This would amount to a decrease of about $600,000 if the distribution of the 43 employees corresponded to the overall distribution.

Exhibit VII
PET Business
Summary of Results Provided by ABC Company

	Postretirement Medical
Hourly:	
Calculation Date	January 1, 1999
Number of Employees	297
Number of Retirees	156
Number of Dependents	133
Discount Rate	6.5%
Liability	$ 25.6 million
Salaried:	
Calculation Date	January 1, 1999
Number of Employees	160
Number of Retirees	0
Discount Rate	7.75%
Liability	$ 2.4 million

	Pension
Hourly:	
Calculation Date	December 31, 1998
Number of Employees	282
Number of Retirees	305
Number of Terminated with Vested Benefits	368
Discount Rate	7.75%
Liability	$ 35.8 million

Salaried:	
Calculation Date	December 31, 1999
Number of Employees	151
Number of Retirees	0
Discount Rate	7.75%
Liability	$ 6.7 million

** TX STATUS REPORT ** AS OF DEC 16 1999 18:25 PAGE.01

BUCK CONSULTANTS

DATE	TIME	TO/FROM	MODE		
06 12/16	18:22	9011441712251485	EC-S		
		MIN/SEC	PGS	JOB#	STATUS
		02'33"	009	176	OK

BUCK
CONSULTANTS
One Mellon Bank Center
500 Grant Street, Suite 2900
Pittsburgh, Pennsylvania 15219-2513

FAX Transmittal

Date: 12/16/99

To: Aly Kanji

Company: Meynor Limited

FAX #: 011-44-171-225-1485

Total Number of Pages (including cover sheet): 9

From: David Jarrett

☐ **RUSH** ☐ Reply ASAP ☐ Please Comment
☐ For Your Review

Message: _____

_____

_____

Original Sent By: ☐ Regular Mail ☐ FedX ☐ Not Sent

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_____

BUCK
CONSULTANTS
One Mellon Bank Center
500 Grant Street, Suite 2900
Pittsburgh, Pennsylvania 15219-2513

December 17, 1999

Mr. Marco Ghisolfi
Vice President – Marketing & Finance
M. & G. Finanziaria Industriale S.p.A.
Centro Direzionale Milanofiori
Strada 4 – Palazzo A6
20090 Assago (MI) Italy

Dear Marco:

We have completed our analysis of the pension and postretirement benefits for both hourly and salaried employees of the PET Division of the Shell Oil Company and are pleased to present a report on our findings.

Background

Shell Oil Company sponsors a number of pension and postretirement medical plans for employees of their PET Division.

Hourly employees are covered under a defined benefit pension plan that provides lifetime benefits based on service. Salaried employees are covered by the Shell Oil Company salaried defined benefit pension plan and receive lifetime benefits based on service and compensation levels. Both salaried and hourly employees receive medical benefits following retirement.

With the purchase of the PET business from Shell Oil Company, M. & G. Finanziaria Industriale has agreed to assume responsibility for these pension and post-retirement medical benefits.

Upon acquisition, M. & G. Finanziaria Industriale will be required to record a liability for these plans on their balance sheet In addition, M. & G. Finanziaria Industriale will be required to accrue an expense each year for the plans. The methodology to be used to calculate the balance sheet liability and annual expense is outlined in Statements No. 87, No. 88 and No. 106 of the Financial Accounting Standards Board. Although the methodology for valuing pension and post-retirement medical benefits is well-defined in these accounting standards, the actuarial assumptions, especially the economic assumptions, are more subject to employer discretion. For this reason, there have been a number of liability amounts put forth by the various parties in the transaction.

Report on Shell Oil Company PET Benefits

The report contained in the balance of this letter is intended to quantify the possible range of liabilities associated with the postretirement pension and medical benefits. In it, we present:

- A restatement of the results as reported by the Shell Oil Company, along with a summary of the data and assumptions used to determine these numbers.

- Our estimate of the results based on the information provided to us.
- Our comments on the results.
- An explanation of possible changes in the results due to changes in the workforce.

If there are any questions regarding the contents of this letter, please feel free to call.

Sincerely,

/s/ David Jarrett
David R. Jarrett
Consulting Actuary

/s/ Duane Lee
Duane Lee
Consulting Actuary

DRJ:DL:ART
Enc.

Exhibit I
PET Business
Summary of Pension Liabilities
as of December 31, 1999
($ Millions)

Pt. Pleasant Hourly			
	Interest Rate		
	6.5%	7.5%	7.75%
Accumulated Benefit Obligation	$ 40.9	$ 36.6	$ 35.7
Projected Benefit Obligation	40.9	36.6	35.7
Market Value of Assets	27.6	27.6	27.6

PET Salaried Spin-Off			
	Interest Rate		
	6.5%	7.5%	7.75%
Accumulated Benefit Obligation	$ 6.1	$ 5.2	$ 4.9
Projected Benefit Obligation	8.6	7.2	6.9
Assets (based on 7.5% transfer)	7.2	7.2	7.2

Definitions:

Accumulated Benefit Obligation (ABO): The liability for benefits based on service and salaries as of the determination date. This is the liability for the plan if benefits were to be frozen.

Projected Benefit Obligation (PBO): The liability for benefits based on service at determination date and salaries projected to termination/retirement. Same as the ABO, except with projected salaries. For non-salary-related plans, such as Pt. Pleasant Hourly, the ABO and PBO are equal.

Exhibit II
PET Business
Discussion of Pension Liabilities

- Plan participants on which liabilities are based were provided by FBD Consulting (Pt. Pleasant Hourly) and Buck Consultants – Houston, TX (PET Salaried). Data was gathered in early November 1999. The participants are summarized below:

	Pt. Pleasant Hourly	PET Salaried
Active	282	151
Terminated with Vested Benefits	368	0
Retirees	305	0
Total	955	151

- Plan assets for Pt. Pleasant Hourly are equal to the market value of assets as provided by FBD Consulting as of November 30, 1999.
- Plan assets for PET Salaried were set equal to the Projected Benefit Obligation calculated at 7.5%. Actual assets will be determined as of the date of the spin-off.
- For the PET Salaried Plan, compensation for participants is assumed to increase on average at 5.5% per year.

Exhibit III
PET Business
Summary of OPEB Liabilities
as of December 31, 1999
($ Millions)

Pt. Pleasant Hourly			
	Interest Rate		
	6.5%	7.5%	7.75%
Accumulated Postretirement Benefit Obligation:			
Actives	$ 9.6	$ 7.5	$ 7.0
Retirees	20.3	18.7	18.3
Total	$ 29.9	$ 26.2	$ 25.3

PET Salaried Spin-Off			
	Interest Rate		
	6.5%	7.5%	7.75%
Accumulated Postretirement Benefit Obligation:			
Actives	$ 3.4	$ 2.8	$ 2.6
Retirees	0	0	0
Total	$ 3.4	$ 2.8	$ 2.6

The above numbers represent our estimate of the postretirement medical obligation using a different medical trend rate and various discount rates.

Definitions:

Accumulated Postretirement Benefit Obligation (APBO): The liability for benefits based on service as of the determination date.

Exhibit IV
PET Business
Discussion of OPEB Liabilities

- Due to time constraints, a detailed actuarial valuation of postretirement medical liabilities was not performed.
- Results as determined by PricewaterhouseCoopers were provided to us along with a summary of the actuarial assumptions.
- A review of the results was made to check for reasonableness based on the information provided. The salaried results were accepted as given due to the lack of information.
- These reported liabilities were adjusted to reflect different assumptions which we deemed to be appropriate. In particular, the liabilities were adjusted to recognize a different medical trend rate. These liabilities were also adjusted to December 31, 1999.
- Information identifying the approximately 70 employees to be terminated at the Pt. Pleasant location before closing is unavailable because the program will be offered to all employees on a voluntary basis.

- While we do not have any actuarial experience to compare, the demographic assumptions do not appear to be unreasonable.
- For comparison purposes, we have shown our estimate of the FAS No. 106 liabilities based on a 6.5%, 7.5% and 7.75% discount rate.
- These numbers assume the active population continues to be actively employed.
- A medical trend rate of 8.5% grading down to 5.0% in 0.5% intervals is assumed. In comparison, Shell Oil Company used a rate of 6.5% grading to 5.0% in 0.5% intervals.

Exhibit V
PET Business
Impact of Employee Reductions of Pensions

- Information identifying the approximately 70 employees to be terminated at the Pt. Pleasant location is unavailable because the program will be offered to all employees on a voluntary basis.
- In order to estimate the impact of reducing different segments of the Hourly Pt. Pleasant workforce, we have estimated the change in Projected Benefit Obligation from terminating the oldest 70 employees, the youngest 70 employees, and a mixture of the two.

	Oldest 70	Youngest 70	Mixed 70
Change in Projected Benefit Obligation			
at 6.5%	$ 2.3	$ (0.3)	$ (0.8)
at 7.5%	2.2	(0.2)	(0.7)

- We have also estimated the impact on the Projected Benefit Obligation of terminating 50 hourly employees at Pt. Pleasant.

	Oldest 50	Youngest 50	Mixed 50
Change in Projected Benefit Obligation			
at 6.5%	$ 2.1	$ (0.2)	$ (0.5)
at 7.5%	2.0	(0.2)	(0.5)

- Although reductions in Pt. Pleasant Salaried employees will change the gross benefit liability, the net benefit liability (PBO less assets) should remain unchanged. Since the terminations are expected to occur before the spin-off of assets, any change in gross liability will result in the same change to assets that are spun-off to the Plan.

- If all but 17 Akron salaried employees remain participants in their current program, gross benefit liabilities will be reduced significantly. Net benefit liabilities should remain unchanged, however, since the assets transferred as part of the spin-off will also be reduced by the same amount that liabilities are reduced.

Exhibit VI
PET Business
Impact of Employee Reductions of OPEB

- A reduction of 70 Pt. Pleasant active employees may increase or decrease the liability depending on the demographics of the group.

  There is a significant cost of providing medical benefits for employees who are eligible for benefits. However, there is an offsetting credit for employees who are not eligible for benefits.

  If the group consists of a large number of employees who are eligible for benefits, then an increase in liability would result. However, if the group consists of young, short-service employees, then a decrease in liability is likely. The most probable scenario is that the two will offset each other.

- The salaried results include 60 Akron employees. If Shell Oil Company retains 43 of these employees, the liabilities shown will be decreased accordingly. This would amount to a decrease of about $600,000 if the distribution of the 43 employees corresponded to the overall distribution.

Exhibit VII
PET Business
Summary of Results Provided
by Shell Oil Company

	Postretirement Medical
Hourly:	
Calculation Date	January 1, 1999
Number of Employees	297
Number of Retirees	156
Number of Dependents	133
Discount Rate	6.5%
Liability	$ 25.6 million
Salaried:	
Calculation Date	January 1, 1999
Number of Employees	160
Number of Retirees	0
Discount Rate	7.75%
Liability	$ 2.4 million

The above results were provided to us by PricewaterhouseCoopers. These numbers formed the basis for our estimates. At a meeting with Shell Oil Company on December 10, 1999, the hourly and salaried results were reported to be $22.8 million and $2.39 million respectively. The difference in the hourly numbers is primarily due to the discount rate. The difference in the salaried numbers is due to rounding.

	Pension
Hourly:	
Calculation Date	December 31, 1998 [sic]
Number of Employees	282
Number of Retirees	305
Number of Terminated with Vested Benefits	368
Discount Rate	7.75%
Liability	$ 35.8 million
Salaried:	
Calculation Date	December 31, 1999
Number of Employees	151
Number of Retirees	0
Discount Rate	7.75%
Liability	$ 6.7 million

Exhibit VIII
PET Business
Comments on Results Provided by Shell Oil Company

- Shell Oil Company has used a 7.75% discount rate to value liabilities, suggesting that 7.75% is the rate they will use for their December 31, 1999 financial disclosures.
- FAS No. 87 and FAS No. 106, the two U. S. accounting standards for benefit plans, give guidance on how discount rates should be selected, but do not give a[n] explicit methodology that must be used to select discount rates.

- To select discount rates, employe[r]s often look to various measures, such as:
  - The yield on U. S. Treasuries.
  - Interest rates implicit in annuity contracts that could be used to settle the obligation.
  - The yield on high-quality corporate debt instruments.
- Based on these measures, we believe most employers will use discount rates between 7.25% and 7.75% as of December 31, 1999, with most falling around 7.50%.
- The medical trend rate should be based on the experience of the plan, along with future expectation of inflation. The independent survey will likely show an initial rate of about 7.5% grading to 5.25% by the year 2004.

HUMAN RESOURCES AGREEMENT FOR U.S. AND MEXICAN EMPLOYEES

This Human Resources Agreement (this "Agreement"), dated this 1st day of June, 2000, is made by and among Shell Oil Company, a Delaware corporation ("SOC"), and Pecten Overseas Holdings Inc., a Delaware corporation ("POHI") and Pecten Overseas Services Company, a Delaware corporation ("POSC") (each a "Seller" and collectively the "Sellers"), and Mossi & Ghisolfi Overseas SA, a Luxembourg company ("Buyer" and collectively with Sellers the "Parties").

WHEREAS, the Parties are also parties to a Purchase and Sale Agreement dated February 3, 2000 among POHI, POSC, Shell Chemicals (U.K.) Limited, Shell Italia S.p.A. and SOC and Buyer that provides for SOC and its Affiliates that are parties thereto to sell their ownership interests in certain chemical companies to Buyer (the "Purchase and Sale Agreement"); and

WHEREAS, it is a condition to Closing under the Purchase and Sale Agreement that the Parties enter into this Agreement;

NOW, THEREFORE, the Parties agree as follows:

Section 1 Definitions/Procedural Conventions.

Unless the context shall otherwise require, terms used and not defined herein shall have the meanings set forth in Schedule A to the Purchase and Sale Agreement, and all rules as to usage and procedural conventions set forth in Schedule A to the Purchase

and Sale Agreement shall govern this Agreement. Schedule A to the Purchase and Sale Agreement is hereby incorporated herein by reference.

Section 2 Companies.

A. Employees in General.

1. Representations and Warranties Regarding List of Employees. Subject to Article VIII of the Purchase and Sale Agreement, SOC represents and warrants to Buyer that SOC has provided to Buyer (prior to the execution of the Purchase and Sale Agreement or as soon thereafter as is reasonably practicable but not later than 15 days after such execution) a true and correct list, as of January 15, 2000, of:

(a) each employee covered by a Collective Bargaining Agreement (as defined below) employed by each U.S. Company, Pecten Group, Servicios Tampico S.A. de C.V. ("Servicios Tampico") or any of the other Company Subsidiaries or by Shell Chemical Company on a substantially full-time basis in support of the Assets as of the date of this Agreement (each, a "Represented Employee");

(b) each regular, full-time employee not covered by a Collective Bargaining Agreement employed by each U.S. Company, Pecten Group, Servicios Tamaulipas S.A. de C.V. ("Servicios Tamaulipas") or any of the other Company Subsidiaries or by Shell Chemical Company on a substantially full-time basis in support of the Assets as of the date of this Agreement (each, a "Nonrepresented Employee" and, collectively with

the Represented Employees, the "Employees"); and

(c) a number designated by Sellers (but not the name or any other information that will identify the Employee without his or her consent *prior to* Closing), together with each Employee's title, current base salary rate, total compensation (including bonuses and commissions), and accrued, unused vacation benefits.

2. Representations and Warranties Regarding Labor Matters. Subject to Article VIII of the Purchase and Sale Agreement, SOC represents and warrants to Buyer as follows:

(a) Shell Polyesters or its predecessor and the Pecten Group and its Subsidiaries are party to and bound by the Collective Bargaining Agreements affecting the Represented Employees. Except for the Collective Bargaining Agreements, no North American Company and no North American Company Subsidiary is a party to any labor agreement with any labor organization, group or association.

(b) Except for negotiations and any resulting amendments associated with the contemplated reduction in employees pursuant to Section 7.13 of the Purchase and Sale Agreement, (i) no collective bargaining agreement is being negotiated by any North American Company or any North American Company Subsidiary, (ii) there is no pending or, to the Knowledge of SOC, threatened labor dispute, strike or work stoppage against any North American Company or any

North American Company Subsidiary, (iii) to the Knowledge of SOC, neither a U.S. Company nor any representative or employee of such Company has in the United States committed any unfair labor practices in connection with the operation of the business of the U.S. Company, and (iv) there is no pending or, to the Knowledge of SOC, threatened charge or complaint against any U.S. Company or any U.S. Company Subsidiary by or before the National Labor Relations Board or any comparable agency of any state of the United States.

3. Representations and Warranties Regarding Employee Benefit Plans. Subject to Article VIII of the Purchase and Sale Agreement, SOC represents and warrants to Buyer as follows:

(a) Schedule 2A3 sets forth an accurate and complete list of (i) each "employee benefit plan," as such term is defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which is maintained by the U.S. Companies for the benefit of their Employees; (ii) to the extent not disclosed in the preceding clause (i), each plan, contract, program or policy, whether written or oral, funded or unfunded, providing stock options, stock ownership, stock purchase or award, phantom stock, stock appreciation rights, deferred compensation, retirement, insurance, flexible spending, dependent care, vacation pay, holiday pay, sick pay, workers compensation, severance or termination pay, supplemental unemployment benefits, employee loans, educational assistance, incentive, bonus or other profit-sharing arrangements for the benefit

of Employees (all in the preceding clauses (i) and (ii), other than plans which will not be maintained by any North American Company or any North American Company Subsidiary after the Closing Date, being collectively referred to as "Employee Plans"); and (iii) an accurate and complete list of all material employment, managerial, advisory, and consulting agreements, employee confidentiality agreements, employee severance agreements and all other material agreements, policies, or arrangements maintained by any North American Company or any North American Company Subsidiary for its Employees, other than such agreements, policies, or arrangements which will not be the responsibility or liability of any North American Company or any North American Company Subsidiary after the Closing Date.

(b) SOC has delivered or made available to Buyer copies, which were accurate and complete as of the date so delivered or made available, of all such Employee Plans and (if applicable) summary plans descriptions with respect to such plans, agreements and arrangements, or summary description(s) of any such plans, agreements or arrangements not otherwise in writing and, except as described in Schedule 2A3, there have been no significant changes to such documents as of the date of this Agreement.

(c) With respect to each Employee Plan, to the Knowledge of SOC, no event has occurred and, there exists no condition or set of circumstances in connection with any Employee Plan which could subject any North American Company or any North American Company Subsidiary to any

liability (other than contribution and other customary liabilities in the normal course of business which relate to periods of time from and after the Closing) under the terms of such Employee Plan or any Applicable Law.

(d) There has been no termination or partial termination of any Employee Plan that is sponsored, maintained, or contributed to by a U.S. Company as of the date of this Agreement (a "Current Employee Plan") nor of any Employee Plan sponsored, maintained, or contributed to by a U.S. Company within six years prior to the date of this Agreement but terminated prior to the date of this Agreement (a "Terminated Employee Plan"). To the Knowledge of SOC, each Current Employee Plan has been, and each Terminated Employee Plan was, operated in substantial compliance with its provisions and with provisions of Applicable Law.

(e) No U.S. Company has during the six years prior to the date of this Agreement: (A) ceased operations at a facility so as to become subject to the provisions of Section 4062(e) of ERISA, (B) withdrawn as a substantial employer so as to become subject to the provisions of Section 4063 of ERISA, or (C) ceased making contributions on or before the date of this Agreement to any Employee Plan subject to Section 4064(a) of ERISA to which a U.S. Company made contributions during such six-year period. Any Terminated Employee Plan which was intended to have been qualified under Section 401 of the Code received a favorable determination letter

from the United States Internal Revenue Service (the "IRS") with respect to its termination.

(f) There are no actions, suits, or claims pending (other than routine claims for benefits) or, to the Knowledge of SOC, threatened against, or with respect to, any Employee Plan that could reasonably be expected to have a Material Adverse Effect and, to the Knowledge of SOC, no facts or circumstances exist that could give rise to any such actions, suits, or claims.

(g) To the Knowledge of SOC, there is no matter pending (other than routine filings) with respect to any Employee Plans before the IRS, the United States Department of Labor, the Pension Benefit Guaranty Corporation, or any other Governmental Entity in the United States.

(h) All contributions required to be made to Employee Plans pursuant to their terms and the provisions of Applicable Law have been made on a reasonably timely basis.

(i) No U.S. Company contributes, or has an obligation to contribute, and has not within six years prior to the date of this Agreement contributed, had an obligation to contribute, or has or had any other liability, to a multiemployer plan within the meaning of Section 3(37) of ERISA.

* * *

B. Represented Employees. Buyer acknowledges that Shell Polyesters or its predecessor is bound by the indicated collective bargaining agreements and all existing memoranda of agreement or understanding

that are listed on Schedule 2B (the "U.S. Collective Bargaining Agreements") between Shell Chemical Company and the United Steelworkers of America, AFL-CIO-CLC) and its Local Union No. 644 (the "Union"). Servicios Tampico is bound by the collective bargaining agreement listed on Schedule 2B (the "Mexican Collective Bargaining Agreement" and, together with the U.S. Collective Bargaining Agreements, the "Collective Bargaining Agreements") between Servicios Tampico and Sindicato de Trabajadores de la Industria Quimica, Petroquimica, Carbonquimica, Similares y Conexos de la Republica Mexicana ("CTM"). Buyer agrees to keep and cause the North American Companies and the North American Company Subsidiaries to keep the Collective Bargaining Agreements in full force and effect for their duration, except for changes mutually agreed to between Buyer and the Union and CTM, as appropriate, or as otherwise permitted by the respective Collective Bargaining Agreement.

1. Successorship.

(a) Buyer agrees to cause Shell Polyesters to be the successor under the "successor clause" (Section 2 of Article XV) of the U.S. Collective Bargaining Agreement from and after the Closing Date. Buyer and Shell Polyesters shall be solely responsible for, and agree to assume, fully perform and discharge, all obligations of the employer, and Buyer agrees to indemnify and hold the Shell Indemnified Parties harmless against any and all Damages arising out of any failure of Buyer or Shell Polyesters to perform

the obligations of employer arising on or after the Closing Date under the U.S. Collective Bargaining Agreements or Applicable Law.

(b) From and after the Closing Date Buyer agrees to cause Pecten Group or Servicios Tampico to fulfill all responsibilities under the Mexican Collective Bargaining Agreement and Applicable Law and Buyer agrees to indemnify and hold the Shell Indemnified Parties harmless against any and all Damages arising out of any failure of Buyer, Pecten Group or Servicios Tampico to perform the obligations of employer arising on or after the Closing Date under the Mexican Collective Bargaining Agreement or Applicable Law.

2. Assumption of Liabilities for Represented Employees. Effective as of the Closing Date, Buyer shall assume all pension liabilities and all retiree health care benefits ("OPEB") liabilities with respect to each of the Represented Employees who elects to accept or continue employment with the Companies as of the Closing Date, in accordance with the terms of this Section 2B and Section 2E hereinbelow.

3. Banked or Deferred Vacation. SOC shall pay Buyer the dollar value of the unused banked or deferred vacation entitlement of each Represented Employee who continues from and after the Closing Date in the employ of Buyer or any of its post-Closing Affiliates.

* * *

E. Adjustment for Assumption of Liabilities. Effective as of the Closing Date (and, where applicable with respect to the 17 or more Employees at the Akron Facility, effective as of the first anniversary of the Closing Date), Buyer shall assume in accordance with this Agreement all pension and OPEB liabilities with respect to each of the Continuing Employees and each of the retirees and deferred vested participants under the Pt Pleasant Pension Plan. Notwithstanding anything herein to the contrary, the Window Program shall not be included in any adjustment of the Initial Purchase Price or any true-up hereunder.

1. Estimated Pension and OPEB Liabilities. Pending the determination of the Final Pension and OPEB Liability Credit as set forth in Section 2E2 below, the pension and OPEB liabilities assumed by Buyer shall be deemed to be $33,000,000 (the "Estimated Pension and OPEB Liability Credit"). As indicated in the Purchase and Sale Agreement, Buyer shall receive an interim credit against the Initial Purchase Price equal to the Estimated Pension and OPEB Liability Credit.

2. Final Pension and OPEB Liability Credit. Eighteen months after the Closing, the "Final Pension and OPEB Liability Credit" shall equal (x) the pension and OPEB liabilities determined in accordance with this paragraph 2, and the terms and provisions of the subject pension and retiree medical plans as they exist on the date of this Agreement minus (y) the sum of: (1) the dollar amount transferred or to be transferred from the Shell Pension Plan to the New

Pension Plan as of the Closing Date and (2) the fair market value of assets in the Pt Pleasant Pension Plan as of the Closing Date.

(a) The dollar value of pension liabilities assumed by Buyer on a projected benefit obligation basis for Nonrepresented Employees shall be determined using the methodology and assumptions followed in the preparation of the Report of the Sixty-first Annual Valuation of Assets and Liabilities of the Shell Pension Plan as of December 31, 1997, for purposes of arriving at the Statement of Financial Accounting Standards ("SFAS") 87 numbers contained therein, a summary of which actuarial methods and assumptions is attached hereto as Exhibit 2E2(a); *provided, however*, that the discount rate assumption shall be determined as the 1999 weighted-average discount rate used in accordance with SFAS 87 as of December 31, 1999, by the defined benefit pension plans of responding Fortune 1000 companies for the purposes of their defined benefit pension plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000.

(b) The dollar value of pension liabilities assumed by Buyer for Represented Employees shall be determined using the methodology and assumptions followed in the preparation of the Shell Oil Company Pension Plan for Bargaining Unit Employees Point Pleasant Plant Actuarial Valuation for Purposes of Determining Contributions for the Plan Year Beginning January 1, 1999, for purposes of arriving at the SFAS 87 numbers contained therein, a copy of which

actuarial methods and assumptions is attached as Exhibit 2E2(b); *provided*, *however*, that the discount rate assumption shall be determined as the 1999 weighted-average discount rate used in accordance with SFAS 87 as of December 31, 1999, by the defined benefit pension plans of responding Fortune 1000 companies for the purposes of their defined benefit pension plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000.

(c) The dollar value of OPEB liabilities assumed by Buyer on an accumulated post-retirement benefit obligation basis for Nonrepresented Employees shall be determined using the methodology and assumptions followed in the preparation of the annual disclosure under SFAS 132 of the SFAS 106 numbers as of December 31, 1999, by Shell Oil Company, a summary of which actuarial methods and assumptions is attached hereto as Exhibit 2E2(c); *provided*, *however*, that the discount rate assumption for this purpose shall be determined as the 1999 average discount rate for other post-retirement benefits used in accordance with SFAS 106 as of December 31, 1999, by the postretirement medical plans of responding Fortune 1000 companies for the purposes of their postretirement medical plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000; and *provided*, *further*, that the current year health care cost trend rate, the ultimate health care cost trend rate, and the year in which the ultimate health care cost trend rate is reached shall be similarly determined as the 1999 average current

year health care cost trend rate, the 1999 average ultimate health care cost trend rate, and the 1999 average year in which the ultimate health care cost trend rate is reached, each as used in accordance with SFAS 106, by the postretirement medical plans of responding Fortune 1000 companies for the purposes of their postretirement medical plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000.

(d) The dollar value of the OPEB liabilities assumed by Buyer on an accumulated post-retirement benefit obligation basis for Represented Employees shall be determined using the methodology and assumptions followed in the preparation of that portion of the annual disclosure under SFAS 132 of the SFAS 106 numbers as of December 31, 1999, by Shell Oil Company that relates to the Represented Employees, a summary of which actuarial methods and assumptions is attached hereto as Exhibit 2E2(d); *provided, however*, that the discount rate assumption for this purpose shall be determined as the 1999 average discount rate for other post-retirement benefits used in accordance with SFAS 106 as of December 31, 1999, by the postretirement medical plans of responding Fortune 1000 companies for the purposes of their postretirement medical plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000; and *provided, further*, that the current year health care cost trend rate, the ultimate health care cost trend rate, and the year in which the ultimate health care cost trend rate is reached shall be similarly determined as the

1999 average current year health care cost trend rate, the 1999 average ultimate health care cost trend rate, and the 1999 average year in which the ultimate health care cost trend rate is reached, each as used in accordance with SFAS 106, by the postretirement medical plans of responding Fortune 1000 companies for the purposes of their postretirement medical plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000.

(e) The dollar value of the nonqualified pension liabilities assumed by the Buyer on an accumulated benefit obligation basis shall be determined using the methodology and assumptions followed in the preparation of the Report of the Sixty-first Annual Valuation of Assets and Liabilities of the Shell Pension Plan as of December 31, 1997, for purposes of arriving at SFAS 87 numbers contained therein, a summary of which actuarial methods and assumptions is attached hereto as Exhibit 2E2(a); *provided, however*, that the discount rate assumption shall be determined as the 1999 weighted-average discount rate used in accordance with SFAS 87 as of December 31, 1999, by the defined benefit pension plans of responding Fortune 1000 companies for the purposes of their defined benefit pension plans, based on a survey to be conducted and published by Buck Consultants, Inc. on or about October 2000.

3. True-Up. Eighteen months after the Closing Date, the Parties shall true up the difference between the Estimated Pension and OPEB Liability

Credit and the Final Pension and OPEB Liability Credit. The true-up shall be calculated as of the first day of the month coincident with, or immediately following, the end of such eighteen-month period. If the Estimated Pension and OPEB Liability Credit is greater than the Final Pension and OPEB Liability Credit, then Buyer shall pay the difference to SOC. If the Final Pension and OPEB Liability Credit is greater than the Estimated Pension and OPEB Liability Credit, then SOC shall pay the difference to Buyer. Any payment required pursuant to this paragraph 3 shall be made within five Business Days after SOC provides a statement to Buyer of the difference, if any, between the Estimated Pension and OPEB Liability Credit and the Final Pension and OPEB Liability Credit.

(a) To the extent that Buyer does not establish pension or postretirement medical plans, as the case may be, within seventeen months after the Closing Date, Buyer shall refund to SOC as part of this true-up process, the amount attributable to the liabilities that were included in the Estimated Pension and OPEB Liability Credit.

(b) The true-up contained in this Section 2E shall be the one and only reconciliation for benefit liabilities with respect to this Agreement and the Purchase and Sale Agreement. There shall be no true-up with respect to any Employees who have not commenced employment with Buyer or its post-Closing Affiliates within eighteen months after the Closing, nor shall there be any true-up with respect to persons who

terminate from Buyer or its post-Closing Affiliates more than eighteen months after the Closing.

(c) If the actual positive rate of return on total Shell Pension Trust assets for the plan year prior to the plan year in which the physical transfer of assets takes place is greater than 3.625 percent per annum, then in addition to the amount of interest paid by Shell Pension Plan on transferring pension assets under Section 2D3(f), SOC shall pay to the Buyer as part of the true-up an amount equal to interest accruing from the Employment Commencement Dates to the actual date of the physical transfer of assets at the rate of 4.125 percent per annum (resulting in Buyer receiving interest from both sources of 7.75 percent).

4. Role of Buyer's Actuary. At the request of Buyer, the actuary for Buyer shall be entitled to view the work papers of the actuary for Sellers, solely for purposes of validating that the methodology and assumptions applied are consistent with the provisions of this Agreement and properly take into account changes in demographics of the Employees and the changes in the discount rates, the current year health care cost trend rate, the ultimate health care cost trend rate, and the year in which the ultimate health care cost trend rate is reached, which changes are expressly set out in this Agreement. When Buyer or Buyer's actuary has viewed the work papers of the actuary for Sellers, Sellers and the actuary for Sellers shall be entitled to view the work papers of the actuary for Buyer, solely for purposes of validating that

the methodology and assumptions applied are consistent with the provisions of this Agreement and properly take into account changes in demographics of the Employees and the changes in the discount rates, the current year health care cost trend rate, the ultimate health Care cost trend rate, and the year in which the ultimate health care cost trend rate is reached, which changes are expressly set out in this Agreement. If Buyer does not dispute the amount of the true-up as determined by the actuary for Sellers, then payment shall be made in accordance with paragraph E3 above on the basis of the determination made by Sellers' actuary. If Buyer disputes the true-up amount as determined by the actuary for Sellers, then within 30 days after the date on which Buyer's actuary commenced its review of the work papers of Sellers' actuary, Buyer shall give notice to SOC of its dispute, which notice shall set forth in reasonable detail the item or items disputed, the amount of each such item that is disputed and the basis for such dispute. The Parties, together with Sellers' actuary and Buyer's actuary, shall promptly commence good faith negotiations with a view to resolving such dispute; *provided* that if such dispute has not been resolved by mutual agreement of the Parties within 30 days after the date of such notice, then within 10 days thereafter, Buyer and SOC shall jointly appoint Hewitt Associates LLC to conduct such validation and present its determination within 30 days of its appointment. The determination of Hewitt Associates LLC shall be final, binding, and conclusive as between Buyer and Sellers. The fees and disbursements of

Buyer's actuary and Sellers' actuary shall be borne by the respective Parties that retained them. The fees and disbursements of Hewitt Associates LLC in connection with the validation made under this paragraph shall be shared one-half by Buyer and one-half by Sellers.

F. Liabilities and Indemnities.

1. To the maximum extent permitted by Applicable Law, SOC shall defend, indemnify, and hold harmless Buyer and Buyer's post-Closing Affiliates from and against any Damages, and any fines, penalties and assessments, arising out of claims by Employees of SOC or any of its Affiliates and that arise out of, or relate to their employment with, or the termination of their employment from SOC or any Affiliates of SOC prior to the Employment Commencement Date (including the pending equal opportunity violation charge (*Yester* v. *Shell Chemical Company*) and the pending employment discrimination charge by a former employee under the West Virginia Human Rights Act (*James E. Jones, II* v. *Shell Chemical Company and Robert Bowen*)).

2. To the maximum extent permitted by Applicable Law, Buyer shall defend, indemnify, and hold harmless SOC and Affiliates of SOC from and against any Damages, and any fines, penalties and assessments arising out of claims by the Continuing Employees that arise out of or relate to their employment with, or the termination of their employment from, Buyer or any of its Affiliates on or after the Employment Commencement Date.

3. Notwithstanding anything herein to the contrary, Buyer shall pay the redundancy and other costs, and shall defend, indemnify, and hold harmless SOC and Affiliates of SOC from and against any Damages, and any fines, penalties and assessments, arising out of or relating to: (a) Buyer's failure to employ at least 17 of the Employees at the Akron Facility effective as of the first anniversary of the Closing Date or (b) the employment with, or the termination of employment from, Buyer or any of its Affiliates of such Employees so employed by Buyer at any time after the first anniversary of the Closing Date.

G. Entitlements. Nonrepresented Employees who terminate from Sellers on, prior to, or after the Closing Date and receive any form of severance benefit from Sellers shall not receive any of the service crediting and other benefits and privileges outlined in this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed by duly authorized representatives of the Parties as of the date first written above.

SHELL OIL COMPANY

By: Shell Chemical Company,
as agent for Shell Oil Company

By: /s/ [Illegible]
Richard M. Oblath
Manager, Mergers, Acquisition & Projects

PECTEN OVERSEAS HOLDINGS, INC.

By: /s/ [Illegible]
Richard M. Oblath
Attorney-in-Fact

PECTEN OVERSEAS SERVICES COMPANY

By: /s/ [Illegible]
Richard M. Oblath
Attorney-in-Fact

MOSSI & GHISOLFI OVERSEAS SA

By: /s/ [Illegible]

Name: MARCO GHISOLFI

Title: DIRECTOR

* * *

SCHEDULE 2B

COLLECTIVE BARGAINING AGREEMENTS

SHELL POLYESTERS:

i) Agreement (Contract No. PP0106) between Shell Chemical Co., Pt. Pleasant Plant and Local 644, United Steel Workers of America, AFL-CIO-CLC.

ii) Pension, Insurance and Service Award Agreement (Contract No. PP0179) between Shell Chemical Co., Pt. Pleasant and Local 644, United Steel Workers of America, AFL-CIO-CLC.

iii) In addition to Agreements in the current contract between Shell Chemical Company and Local

Union 644 of the United Steelworkers of America, the following Letters of Agreements and Letters of Understanding exist:

12-21-99 Letter of Agreement—Employees transferring from bargaining unit

5-24-99 Letter of Agreement—Employee changes shift assume high OT opportunities.

5-17-99 Letter of Understanding—1999 Summer recall

9-24-98 Letter of Understanding—Department 104 probationary period

7-20-98 Letter of Agreement—Work force restructuring project

7-15-98 Letter of Understanding—Temporary workers

5-27-98 Letter of Agreement—Pension Plan Amendments 1998

11-4-96 Letter of Understanding—Deferred Vested Pension and Savings Plan Amendments for those laid-off in 1996 and 1997.

11-4-96 Letter regarding keeping employees whole when errors are made on holiday work assignments.

SERVICIOS TAMPICO:

i) Collective Labor Agreement (Contract No. AL0205) between Servicios Tampico S.A. de C.V. and Sindicato de Trabajadores de la Industria Quimica, Petroquimica, Carboquimica, Similaresy Conexos de la Republica Mexicana.

SERVICIOS ALTAMIRA:

i) Servicios Altamira S.A. de C.V.'s collective bargaining agreement on November 30, 2000.

* * *

Exhibit 2E2(c)

Shell Oil Company
Chemical Divestiture

Actuarial Assumptions

Demographic Assumptions

Mortality — The 1983 Group Annuity Mortality Table for males and females.

Retirement Age — Based upon pension assumptions. Illustrative rates of retirement are shown below:

Age	Annual Rate of Retirement
50	3.42%
55	6.50%
60	30.00%
62	50.00%
65	60.00%
66	40.00%
67	40.00%
68	30.00%
69	50.00%
70	100.00%

Termination	Based upon pension assumptions. Illustrative rates are shown below, with termination rates 20% and 10% higher during first and second years of employment, respectively.

Age	Annual Rate of Termination Vested	Non-Vested
25	9.01%	9.01%
30	4.88%	6.42%
35	3.27%	5.68%
40	2.06%	5.18%
45	1.95%	5.84%

Exhibit III (continued)

Disability	Disability was considered insignificant and was not considered separately in the valuation. In this valuation, disabled participants are assumed to retire and receive medical benefits at the same retirement ages as assumed for active participants.
Dependents of Future Retirees Covered by Program	85% of active male employees and 65% of active female employees are assumed to be married.
Spouse Age Difference—Future Retirees	Male spouses were assumed to be four years older and female spouses were assumed to be four years younger than the retired employee.

Coverage	It was assumed that 100% of active employees expected to retire in the future will elect to participate in the medical programs.
HMO and Indemnity Plan Participation (Non Belpre Plant)	It was assumed that 30% of all future retirees will participate in an HMO. An assumption for current retirees was not needed, since coverage is based on retirees' actual elections.
HMO and Indemnity Plan Participation (Belpre Plant)	It was assumed that 100% of all future retirees would continue in the indemnity plan.

Economic Assumptions

Discount Rate	As shown in Exhibit 1

Health Care Trend Rate — The trend rates applied to the defined dollar amounts are assumed to be as follows:

	HMO Trend Rate		HSM Defined Benefit	
Year	Pre-65	Post-65	Pre-65	Post-65
1998	7.00%	7.00%	0.00%	7.00%
1999	6.50%	6.50%	0.00%	6.50%
2000	6.00%	6.00%	6.00%	6.00%
2001	5.50%	5.50%	5.50%	5.50%
2002 & later	5.00%	5.00%	5.00%	5.00%

The HMO trend rate shown above is the underlying expected increase in HMO

costs. A zero percent trend was actually used through 1999 to reflect the phase-in of employer contributions to an amount not greater than 80% of the HMO premium or the defined dollar amount the company contributes to the HSM plan.

Company Cost (Non-Belpre Plant)

HSM — The Company contributes 80% towards the premium (contribution into a VEBA used to pay medical claims). The amount of the premium is determined annually. The Company's 1998 contribution is shown below.

Company Contribution Amounts

	Non-Medicare Eligible	Medicare Eligible
Single	$160.50	$ 84.60
Family	$435.50	$169.20

HMO — The Company will contribute a dollar amount equal to 80% of the HMO premium. The Company will finish the phase into this premium sharing arrangement over the next year. The Company will pay 85% in 1998 and 80% in 1999 and later, subject to certain minimums.

Shell participates in various HMOs, the average of these premiums reflected in the valuation are as follows:

		Non-Medicare Eligible	Medicare Eligible
	Single	$155.00	$ 50.00
	Family	$445.00	$100.00

Belpre Plant		Non-Medicare Eligible	Medicare Eligible
	Single	$160.50	$ 70.47
	Family	$435.50	$240.95

Medicare Part B — Medicare Part B premiums are paid by retirees and consequently, these premiums do not affect the valuation.

* * *

Exhibit IV
(continued)

Shell Oil Company
Chemical Divestiture
Point Pleasant Union Plan

Actuarial Assumptions

Disability — Disability was considered insignificant and was not considered separately in the valuation. In this valuation, disabled participants are assumed to retire and receive medical benefits at the same retirement ages as assumed for active participants.

Dependents of Future Retirees Covered by Program	85% of active male employees and 85% of active female employees are assumed to be married. An assumption for dependents of current retirees was not needed, since actual data for current dependents was provided.
Spouse Age Difference—Future Retirees	Male spouses were assumed to be four years older and female spouses were assumed to be four years younger than the retired employee.
Coverage	It was assumed that 100% of active employees expected to retire in the future will elect to participate in the medical programs. Participation of current retirees (and dependents) was based on information provided and those retirees (and dependents) currently participating in the programs were assumed to continue their participation.

Economic Assumptions

Discount Rate	As shown on Exhibit 1
Health Care Trend Rate	The trend rates applied to the per capita costs are assumed to be as follows:

	Trend Rate	
Year	Pre-65	Post-65
1998	7.50%	7.50%
1999	7.00%	7.00%

2000	6.50%	6.50%
2001	6.00%	6.00%
2002	5.50%	5.50%
2003 & later	5.00%	5.00%

Per Capita Cost	January 1, 1998 Valuation
Age 55	$4,013
Age 60	$4,419
Age 62	$4,620
Age 65	$1,384
Age 70	$1,410

Medicare Part B — Medicare Part B premiums paid by the Company are assumed to be limited to $526 per year.

Exhibit V

Shell Oil Company
Chemical Divestiture
Point Pleasant Union Plan

Actuarial Assumptions

Coverage	Lifetime for Retirees and Spouses	
Deductible	$175 per individual per annum	
Coinsurance	85% after deductible until out of pocket maximum is met, 100% thereafter.	
Out of Pocket Maximum	Individual	$750 per year
	Family	$1,100 per year
Lifetime Maximum	$1,500,000 per person	

Retiree Contributions	None
Medicaid Part B Premium	Employer paid

PricewaterhouseCoopers LLP November 15, 1999

[Received From Co. 10/17/00 @ 3:40 pm]

COMPANY RESPONSE TO UNION'S OCTOBER 11, 2000 INQUIRY RE THE P&I AGREEMENT

October 17, 2000

Provided that the Company can obtain necessary changes allowing it the flexibility it seeks, the Company is willing to make improvements to the pension plan in terms of an increase to the multiplier (in each year of the contract); an increase to the supplemental benefit; removal, to the extent possible, of earnings limitations; and a common expiration date for the P&I Agreement and the basic labor agreement.

The applicability of Letter H (FASB language?) to the P&I Agreement and to M&G is less than clear. In fact, the Company believes it does not apply to M&G (or Shell previously). Retiree health benefit contributions are set out on page 115 of our P&I Agreement. Letter H is not in our Agreement.

The supplement cannot be guaranteed to be consistent with any changes in social security eligibility, as the Company has no way of knowing what that might be. The potential for unfunded liability is too great.

Understand that the aforementioned are economic improvements and will be considered in keeping with other economic demands of the Union. All language of the P&I Agreement must be specific to M&G and Local 644 only. The big question is, do we both

agree as to what the P&I Agreement will contain? The Union appears to be referencing some Master Agreement, while the Company maintains it is the blue book specific to the parties.

PENSION, INSURANCE AND SERVICE AWARD AGREEMENT

Effective November 6, 2000

Between

M&G Polymers USA, LLC
Apple Grove Plant

and

Local Union 644L

of the

United Steelworkers of America
AFL-CIO-CLC

* * *

FOREWORD

The following pages contain the Pension, Insurance and Service Award Agreement dated November 6, 2000, by and between M&G Polymers, USA, LLC and United Steelworkers of America, effective November 6, 2000 on behalf of Local Union 644L.

Upon the adoption of the amendments to the 1993 Pension Plan of Shell Chemical Company provided for in the Pension, Insurance and Service Award Agreement dated May 9, 1997, the full text of the 1993 Pension Plan, as applicable to Employees covered by said Agreement who are also covered by the Plan and who retire on or after May 1, 1997, will be as set forth in the Exhibit A appearing at the end hereof.

PENSION, INSURANCE, AND SERVICE AWARD AGREEMENT

THIS AGREEMENT is made and entered into this 6th day of November, 2000, by and between the M&G POLYMERS, USA, LLC and UNITED STEELWORKERS OF AMERICA, and the local union listed below.

Wherever used in this Agreement:

(a) The term "Basic Agreement" means the present agreement dated November 6, 2000, between the parties hereto, or any new agreement, replacing such present agreement, hereafter entered into between the parties hereto; and the term "1994 Agreement" means the Pension, Insurance and Service Award Agreement entered into between the parties on July 20, 1994;

(b) The terms "Company" and "Employer" each mean the M&G POLYMERS, USA, LLC;

(c) The term "Employee" means any employee of the Employer who, during the term of this Agreement, shall be in the bargaining unit covered by the Basic Agreement;

(d) The term "Union" means the UNITED STEELWORKERS OF AMERICA; and

(e) The term "Local Union" means, as to the Point Pleasant, West Virginia Plant covered by this Agreement, the Local Union 644L which is the exclusive bargaining agency of

the employees in the bargaining units at such plant.

This Agreement is executed by representatives of the Union and by members of the International Policy Committee who represents the Local Union Involved.

PART I

PENSION PLAN

Pursuant to a certain Pension and Insurance Agreement dated December 18, 1992, by and between certain of the parties hereto, there has heretofore been established the 1993 Pension Plan of the Company, which, as amended pursuant to the 1994 Agreement, is now in full force and effect. Subject to the conditions specified in Part II hereof, with respect to favorable action by the Board of Directors and the Internal Revenue Service, the parties hereto agree that the 1993 Pension Plan (hereinafter referred to as the "Plan") shall, with respect to Employees covered by this Agreement who are also covered by the Plan and who retire, die, or whose employment is otherwise terminated on or after May 1, 1997, be amended in the respects set forth in Exhibit A attached to and made a part of this Agreement; and the parties hereto further agree that the Plan, as so amended, shall be continued in effect with respect to such Employees for the duration of this Agreement.

PART II

CONDITIONS AND SPECIAL PROVISIONS WITH RESPECT TO PENSION PLAN

* * *

2. It is further expressly agreed that the amendments to the 1993 Pension Plan contained in the attached Exhibit A and made pursuant to this Agreement shall be contingent upon and subject to obtaining a ruling of the Internal Revenue Service to the effect that the 1993 Pension Plan,—if amended in the respects set forth in the attached Exhibit A, will continue to meet the requirements of Section 401(a) of the internal Revenue Code, and that the trust created for the purpose of providing benefits under the 1993 Pension Plan will continue to be an exempt trust under Section 501 (a) of the Internal Revenue Code. If the requirements of the Internal Revenue Service shall necessitate any further modifications in said 1993 Pension Plan, the Company shall promptly notify the International Union, and representatives of the parties hereto shall meet within ten days thereafter for the purpose of negotiating with regard to such modifications.

3. The Company shall have the right at any time to change, in whole or in part, the means through which benefits under the 1993 Pension Plan shall be provided, including the establishment of a pension trust or trusts in addition to that heretofore established, and entering into an insurance company contract or contracts. The Company agrees, that, so long as this Agreement is in effect, payments will be made by the Employer,

through contributions to any such trust or payments under any such insurance contract, in at least such amounts as, in the opinion of a qualified actuary, are required at the end of each year to meet at such time the minimum funding requirements now in effect for qualified plans, under applicable rulings and regulations issued by the Internal Revenue Service, and further agrees that there will be provided in such pension trust or trusts or by means of such insurance contract or contracts, assets having value at least equal to amount sufficient, as determined by a qualified actuary on a sound actuarial basis, to provide for the payment of all pensions theretofore awarded to Employees under the 1993 Pension Plan. Such estimates and determinations shall be made at annual intervals.

* * *

5. Any pension plan or pension program previously established by the Employer, other than the 1993 Pension Plan, may be withdrawn or terminated without negotiations of any kind with the International Union or any Local Union, so long as such withdrawal or termination does not reduce any pension benefit to be provided under the 1993 Pension Plan as amended in respects set forth in the attached Exhibit A.

* * *

PART V

INSURANCE

SECTION A—BASIC LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, OPTIONAL CONTRIBUTORY LIFE INSURANCE, AND SURVIVOR INCOME BENEFITS

Effective November 6, 2000, and for the duration of this Agreement thereafter, the Employer will provide the following standard form basic life insurance, accidental death and dismemberment insurance, optional contributory life insurance, and survivor income benefits for regular full time Employees beginning on the 31st day of employment:

1. Basic Life Insurance and Accidental Death and Dismemberment Insurance.

   (a) Effective April 23, 2000 the amount of basic life insurance benefit for each Employee shall be $40,000 and the amount of accidental death and dismemberment insurance shall be $40,000.

   The amount of insurance payable in the event of the death of the Employee will be payable to the named beneficiary in accordance with the terms described in this Program.

   (b) The full amount of basic life insurance benefits will be payable to the beneficiary in the event of the death of the Employee from any cause, at any place at any time while insured under the Program.

(c) The full amount of the accidental death and dismemberment insurance benefit shall be payable if an accident causes the loss of:

Life
Both hands
Both feet
One hand and one foot
One hand and sight of one eye
One foot and sight of one eye
Sight of both eyes

One-half of such amount shall be payable if an accident causes the loss of one hand, one foot, or the sight of one eye; provided, however, that the full amount will be paid only once to or on account of any Employee.

The amount of insurance, subject to due proof of claim loss, will be payable to the Employee if living, otherwise to the beneficiary in accordance with the terms described in this Program.

Accidental death and dismemberment insurance benefits will be payable upon due proof that such loss resulted, directly and independently of all other causes, from bodily injuries caused by an accident occurring while the Employee was covered by this Program.

With respect to a hand or a foot, "Loss" means dismemberment by severance through or above the wrist or ankle joint. With respect to an eye, "Loss" means the entire and irrecoverable loss of the sight of such eye. With respect to losses involving

partial loss of a bodily member or the partial loss of the sight of an eye, "Loss" shall also mean the loss of all functional use of the hand, foot or eye.

Accidental death and dismemberment insurance does not cover any loss caused directly or indirectly, wholly or partly, or contributed to substantially, by bodily or mental infirmity, or ptomaines, or bacterial infections (except pyogenic infections which occur through an accidental cut or wound); or any other kind of disease; or medical or surgical treatment (except such as may result directly from surgical operations made necessary solely by injuries); or war, or any act of war; or suicide, sane or insane.

(d) BENEFICIARY

(i) The Employee may designate a beneficiary or beneficiaries or change the designation of such beneficiary or beneficiaries from time to time by written notice on form provided by the Employer. Such designation or change will take effect as of the date of execution of such request but without prejudice to the Employer on account of any payments made prior to receipt of such request.

If any designated beneficiary predeceases the Employee, the share which such beneficiary would have received if surviving the Employee will be payable equally to the remaining designated

beneficiary or beneficiaries, if any, who survive the Employee.

If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made to the Employee's spouse, if surviving the Employee; if not surviving the Employee, in equal shares to the Employee's children who survive the Employee; if none survives the Employee, to the Employee's parents, equally, or to the survivor; if neither survives the Employee, in equal shares to the Employee's brothers and sisters who survive the Employee; or, if none survives the Employee, to the Employee's executors or administrators.

In any case, the insurance Company may, on instructions from the Employer, deduct from the benefits payable an amount not to exceed $1,000 to cover expenses incurred for the Employee's burial.

(ii) Payment of death benefits will be made in one sum upon proof of claim. The beneficiary may, after death of the Employee but before payment is made, elect that the whole or any part of the benefit be payable in accordance with method (1) or (2) below or in accordance with such other method of settlement as shall be elected by the beneficiary and agreed to by the Insurance Company.

(1) Payment in equal monthly installments extending over a fixed period

of years. The fixed period of years must be specified in the election and may not exceed twenty, and in no event will the Insurance Company be required to pay an installment of less than $10.00 to any one person.

(2) Payment in monthly installments of any fixed amount specified in the election (which may not be less than $5.00 per month per $1,000 so payable nor less tha[n] $10.00 per month regardless of the amount so payable), until the amount so payable with interest is exhausted. With respect to each such election, the rate of interest to be allowed on the unpaid balance shall be determined by the Insurance Company but shall in no case less than 3% per annum.

At the death of a beneficiary to whom a death benefit claim is being paid under method (1) or (2) above, the present value of any unpaid installments under method (1) above, commuted on the basis of 3% interest per annum, or any unpaid balance under method (2) above, as the case may be, will be paid in one sum to the executors or administrators of the beneficiary.

(e) The insurance coverage described in Paragraph 1(a) of this Section A shall be likewise provided for any Employee absent on the Effective Date, under a leave of absence

granted by his Employer, and the insurance coverages provided to any Employee in accordance herewith shall be continued in force during the period of any absence for which he is granted a leave of absence by his Employer, except in cases where such Employee is employed by a Local Union in other than an official or representative capacity, or is employed in any capacity by the International Union.

(f) If an Employee for whom insurance coverages are provided in accordance herewith shall be retired on a disability pension under the 1993 Pension Plan, the full amount of his basic life insurance (but not his accidental death and dismemberment insurance) shall be continued in force for the period of such disability (subject to the furnishing of due proof of its continuance) or until he attains age 65, whichever first occurs. In the event such disability continues after attainment of age 65, the amount of basic life insurance shall be reduced on the first day of the month following the month in which he attains age 65 and on the first day of each succeeding month thereafter by an amount equal to 1/30th of the difference between $2,250 and the amount of basic insurance in effect at the time of his retirement; provided, however, that such monthly reductions shall not operate to reduce the amount of basic insurance below a minimum amount of $2,250, which minimum amount shall then be continued in force during such Employee's remaining lifetime.

(g) Except as provided herein, all insurance coverages provided hereunder for any Employee, other than a laid-off Employee, shall cease on the date 31 days following any termination of such Employee's active employment; all insurance for a laid-off Employee shall cease on the date 90 days following termination of active employment; provided, however, that the basic life insurance (but not the accidental death and dismemberment insurance) benefit shall be continued in force for all Employees who retire and receive a monthly pension under the normal or early retirement provisions of the 1993 Pension Plan, and for all Employees who receive a Service Award (as distinguished from a Service Award Monthly Benefit and any benefit payable under Articles XII and XIII) under the 1993 Pension Plan subject to reduction on the first day of the month following the month in which he receives a Service Award, or in the case of normal or early retirement, retires or attains age 62, whichever later occurs, and on the first day of each succeeding month thereafter in an amount equal to 1/30th of the difference between $2,250 and the amount of basic insurance in effect at the time of his retirement until the amount of basic insurance is reduced to a minimum coverage of $2,250; provided, however, that for Employees who continue in employment after attaining age 65 and retire with a normal retirement pension, his amount of basic life insurance on the first day of the month following the month of retirement shall be

determined as if he had retired upon attainment of age 65 with the applicable reductions from age 65; and provided further that in the case of any other Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated at or after his attainment of age 60, basic life insurance (but not accidental death and dismemberment insurance) coverage in the amount of $2,250 shall be made effective with respect to such Employee as of the first day of the month for which he receives a deferred vested pension, and shall thereafter be continued during his lifetime. If an Employee returns to active employment within such time and under such circumstances that he is credited with previous service in accordance with the Basic Agreement, insurance shall be immediately provided for him in the amounts set forth in Paragraph 1(a) of this Section A.

A laid-off Employee may, within 90 days following layoff, arrange to continue the full amount of his basic life insurance coverage and accidental death and dismemberment insurance by payment in advance at the rate of $0.55 per $1,000 of insurance per month for the period equal to the maximum number of full weekly SUB benefits to which Employee's credit of last day worked prior to layoff would entitle him under the Supplemental Unemployment Benefits Plan but not less than 24 months following the date of layoff, provided, however, that upon acceptance of any benefit payable under Article

XIII of the 1993 Pension Plan, the Employee shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this subparagraph (g).

(h) Conversion Privilege. In case of termination of insurance coverage for any reason whatsoever, the Employee will be entitled to have a policy of life insurance issued by the Insurance Company without further evidence of insurability, provided:

(i) the amount of the policy may not exceed the amount of the Employee's life insurance under the Program at the time the coverage terminated,

(ii) the policy must be upon one of the non-participating forms then customarily being issued by the Insurance Company, except Term Insurance,

(iii) the policy will require payment of the premium applicable to the class of risk to which the Employee then belongs and to the form and amount of the policy at the Employee's then attained age,

(iv) written application for such a policy and payment of the first premium must be made by the Employee within thirty-one days after termination of such coverage and such policy will become effective at the end of such thirty-one days.

The Employee whose insurance is reduced because of (1) being retired on pension, (2) being granted a service award, or (3) attaining age sixty-five while retired on a disability pension under the 1993 Pension Plan will, to the extent set forth below, be entitled to the rights granted under this section:

(i) If the Employee's insurance is, in accordance with the terms of the Program subject to only one such reduction, the Employee will be entitled to said rights, as to the amount of the reduction, as though coverage had terminated on the date of the reduction in insurance.

(ii) If the Employee's basic insurance is, in accordance with the terms of the Program subject to more than one such reduction, the Employee will, on the day of the first such reduction and on the first day of the sixth, twelfth, eighteenth, and twenty-fourth calendar months following the day of the first reduction, be entitled to said rights, in an amount equal to one-fifth of the difference between $2,250 and the amount of insurance in effect at the time of his retirement, as though the Employee's coverage had terminated on that day.

(iii) If the Employee's Optional Contributory Life insurance is, in accordance with the terms of the Program, subject to more than one such reduction, the Employee will, on the day of the first such

reduction and on the first day of the fourth, seventh, and tenth calendar months following the day of the first reduction, be entitled to said rights, in an amount equal to 25% of the amount of insurance in effect at the time of his retirement, as though the Employee's coverage had terminated on that day.

If the Employee fails to exercise any conversion right from a reduction in the amount of his insurance, the Employee will not, thereafter, be entitled to convert the amount of any subsequent reduction in the amount of his insurance.

If the Employee dies during the thirty-one day period within which he is entitled to have an individual policy issued to him under the conversion privilege and before any such individual policy has become effective, the amount of life insurance which the Employee is entitled to have issued to him under such individual policy payable as a claim under the Program, whether or not application for the individual policy or the payment of the first premium therefore has been made.

(i) It is the intent of this Paragraph 1 that Employees shall be provided, beginning May 9, 1997, without cost to them, with the basic life insurance and accidental death and dismemberment insurance benefits previously provided under existing group insurance plans underwritten by Aetna Life Insurance

Company, including the benefit increases provided in Paragraph 1(a) of this Section A.

(j) Assignment—Claims of creditors. Neither the Employee nor the beneficiary may assign the insurance or other benefits under this Program.

Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under the program shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Employee or his beneficiaries.

2. Optional Contributory Life Insurance.

(a) Employees who are covered for Basic Life Insurance benefits will also be eligible to enroll for and be covered by Optional Contributory Life Insurance.

(b) Eligible Employees must enroll and authorize deductions of contributions for Optional Contributory Life Insurance based upon the following schedule:

CONTRIBUTION PER $1,000 OF INSURANCE

Age	Per Month
Under 30	$.25
30-34	.30
35-39	.35
40-44	.40
45-49	.45
50-54	.50

55-59	.55
60-64	.60
65-69	.70
70 and over	.80

(Monthly contributions will be based on Employee's current age)

(i) The initial enrollment period will be the thirty-one (31) days following the Effective Date and the coverage will become effective upon enrollment.

(ii) For Employees hired after the Effective Date, coverage will become effective on the day the Life Insurance, pursuant to Paragraph 1 of this Section A, becomes effective, provided the Employee enrolled on or prior to that date.

(c) A medical examination at the Employee's expense may be required to provide evidence of insurability satisfactory to the carrier:

(i) if the Employee does not enroll during the enrollment periods described in (i) of sub-paragraph (b) above;

(ii) if an Employee hired after the Effective Date does not enroll within thirty-one (31) days after becoming eligible;

(iii) if an Employee who elected an amount equal to 50%, 100% or 200% of Basic Life Insurance elects an increased amount;

(iv) or if the Optional Contributory Life Insurance previously terminated because

an Employee revoked the required payroll deduction authorization.

(d) Employees enrolled for Optional Contributory Life insurance may elect to be insured for an amount equal to 300%, 200%, 100% or 50% of their Basic Life Insurance.

Employees enrolled for Optional Contributory Life Insurance will be provided with Dependent Life Insurance as follows:

For Employees electing 300% of coverage:

Spouse	$20,000
Child	$ 7,000

For Employees electing 200% of coverage:

Spouse	$15,000
Child	$ 5,000

For Employees electing 100% of coverage:

Spouse	$10,000
Child	$ 3,500

For Employees electing 50% of coverage:

Spouse	$ 5,000
Child	$ 2,000

(i) A "dependent" means the Employee's spouse, if married at least a year prior to death or the Employee's unmarried child at least six months of age but under nineteen years of age, however, any person who is in full-time military service shall not be considered a dependent.

(ii) A "child" means the Employee's own natural or legally adopted child or step child who lives with either parent and depends upon the Employee for support and maintenance.

The word "child" means in addition to the Employee's own children as defined above, such foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If an Employee acquires a child dependent other than by birth, legal adoption, or marriage such dependent shall not become eligible until three months have elapsed from the date such child was added to the Employee's medical enrollment.

(iii) The amount of insurance payable under the Dependent Life Insurance provision shall be payable to the Employee in the event of death of the Dependents from any cause.

(e) Optional Contributory Life Insurance is payable in event of death from any cause while an Employee is insured. The insurance will be paid to the beneficiary designated by the Employee under the Basic Life Insurance and Accidental Death and Dismemberment Insurance plan.

(f) The Optional Contributory Life Insurance coverage shall cease on termination of an

Employee's active employment, including any layoff or retirement.

However, Employees who retire and receive a monthly pension with a normal, disability or early retirement pension under the 1993 Pension Plan and who have made all contributions required in the 24-month period immediately preceding the date of retirement will have the Employee's and his dependent's insurance continued without payment of monthly contributions in accordance with the following schedule:

PERIOD AFTER RETIREMENT FOR WHICH EMPLOYEE'S INSURANCE WILL BE CONTINUED WITHOUT CONTRIBUTIONS	PER CENT OF OPTIONAL CONTRIBUTORY LIFE INSURANCE IN EFFECT AT RETIREMENT TO BE CONTINUED
1st through 3rd month	100%
4th through 6th month	75%
7th through 9th month	50%
10th through 12th month	25%

Moreover, commencing with the 13th month after retirement the Employee's insurance, but not the Dependent's insurance, will be continued during the Employee's remaining lifetime, provided such Employee also has made all contributions required for the 120 months immediately prior to the date of retirement, in accordance with the following schedule:

Amount of Coverage Elected	Amount of Insurance Continued
300%	$ 6,400
200%	$ 4,900
100%	$ 3,400
50%	$ 2,400

In no event, however, will the amount to be continued be based on any increase in the amount of insurance which the employee voluntarily elected within the 24-month period immediately preceding date of retirement.

Employees who are covered for Basic Life Insurance, pursuant to Paragraph 1 of this Section A, during layoff, leave of absence, or sick leave, may while so covered, also continue the Optional Contributory Life Insurance coverage by making arrangements for the required monthly contributions to be paid directly to the Employer. Optional Contributory Life Insurance coverage will also terminate if the Employee fails to make the required contributions within thirty-one (31) days following written notice of contributions due, mailed to the last address on file with the Employer. Optional Contributory Life Insurance is subject to the conversion privilege upon termination of such insurance.

* * *

SECTION B—COMPREHENSIVE MEDICAL BENEFITS PROGRAM AND EMPLOYEE SAVINGS PLAN FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January 1, 1998 and for the duration of this Agreement thereafter, the Employer will provide a Comprehensive Medical Benefits Program and Employee Savings Plan as described in Exhibit B attached hereto and made a part hereof by reference.

The foregoing shall be not construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

An Employee who retires and receives a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII, XIII of the 1993 Pension Plan) and is eligible for benefits under Exhibit B shall have his medical benefits after retirement provided under Exhibit B; provided, however, that each Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also receive such benefits effective as of the first day of the month for which he receives a deferred vested pension.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Effective January 1, 1989, and consistent with the provisions of COBRA and any subsequent amendments thereto, the Company will make available the options for continuation of health care coverage prescribed by COBRA, to employees, spouses, former employees, former spouses and former eligible dependents. The medical benefit continuation options prescribed by COBRA shall be concurrent with any continuation of benefits otherwise provided in this Section B and Exhibit B-1.

SECTION C—ACCIDENT AND SICKNESS BENEFITS

Effective November 6, 2000, and for the duration of this Agreement thereafter, the Employer will provide the following plan of accident and sickness benefits for all Employees.

* * *

SECTION D—SUPPLEMENTAL WORKERS' COMPENSATION BENEFITS

Effective May 9, 1997, and for the duration of this Agreement thereafter, the Employer will provide the following Supplemental Workers' Compensation Benefits:

* * *

SECTION E—DENTAL BENEFITS FOR EMPLOYEES AND DEPENDENTS

Effective November 6, 2000 and for the duration of this Agreement thereafter, benefits will be payable for eligible charges which are incurred in connection with a non-occupational accident or illness of an Employee or eligible dependent for Endodontic, Periodontic and Oral Surgery procedures, performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medicine (M.D.) acting within the scope of his license, which are described in the Schedule of Dental Procedures (made a part hereof by reference).

* * *

6. Benefits on Plant Closure

In the event of a Plant Closure at any plant covered by the Agreement, the coverage under this Paragraph 6 is provided in lieu of all other coverage under Part V, Section A of the Agreement and Exhibit B-1. However, upon termination of coverage under this Paragraph 6, the conversion privileges of Part V, Section A, Paragraph 1 of the Agreement and Exhibit B-1 as well as termination provisions of Exhibit B-1 shall apply.

Coverage under Part V, Section A of the Agreement will be extended following such Plant Closure without cost to the Employee for an additional 27 months beyond Employer-furnished coverages provided in Paragraphs 1 and 3 of Section A. Coverage under Exhibit B-1 will be extended following such Plant Closure without cost to the Employee for an additional 12 months beyond

Employer-furnished coverages provided in Exhibit B-1. However, in no event shall the coverage provided in Exhibit B-1 be less than 9 months. For any month in which Employer-furnished coverage is provided under Paragraph 1, Part V Section A of the Agreement, the Employee may continue to purchase coverage under Paragraph 2 of Section A.

In addition to the Employer-furnished coverage provided above, for any month in which the Employee has Credit Units remaining under the Shell Supplemental Unemployment Benefits Plan, coverage under Exhibit B-1 may be continued up to an additional 12 months by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage. The maximum period of coverage under this Paragraph 6 shall be 30 consecutive months for coverage under Part V, Section A, Paragraphs 1 and 3 and 36 consecutive months for coverage under Exhibit B-1 following the month in which such Plant Closure occurred.

Coverage under this Paragraph 6 will not continue as provided above while the Employee is covered by any other Employer sponsored life insurance or medical benefit program; however, when he ceases to be covered by any such other program, he may then resume coverage hereunder for the remainder of the maximum period of coverage as defined above. In order to remain eligible for continued coverage as provided above, the Employee must maintain such coverage continuously except as provided above in this Paragraph 6.

PART VI

DURATION AND TERMINATION

1. Subject to the conditions set forth in Part II hereof, this Agreement shall become effective as otherwise set forth in this Agreement, upon approval by a majority of the Local unions representing a majority of the membership and by the International Executive Board of the international Union, and shall then supersede the 1994 Agreement. Should this Agreement not have been approved by a majority of the Local Unions representing a majority of the membership and by the International Executive Board of the International Union prior to May 30, 1997, all references in this Agreement (and the Exhibits hereto) to May 9, 1997, shall be construed to refer to the date as of which such approval is given.

2. This Agreement constitutes a settlement for the duration of this Agreement of all issues with respect to the subject matters covered hereby, and, while this Agreement continues in effect, the Employer shall have no obligation to negotiate or bargain with the International Union or any Local Union (except as noted in connection with grievance procedures) with respect to any subject matter covered hereby, nor shall there be any strike or work stoppage with respect to such matters. Any termination of the Basic Agreement in accordance with the provisions thereof shall not affect the duration of this Agreement nor shall such termination of the Basic Agreement be deemed to open for negotiation the subject matters covered by this Agreement. The fact that this Agreement continues in effect shall not

prevent the parties from engaging in a strike or lockout with respect to any subject matter not covered by this Agreement, if such strike or lockout may be engaged in lawfully under the terms and provisions of the Basic Agreement.

3. The International Union or the Employer may request renegotiation of the provisions of this Agreement and termination of the Basic Agreement and local supplements thereto by giving a written notice to the other party not more than 75 days nor less than 60 days prior to November 6, 2003, or any November 6 thereafter. In such event, if negotiations are not completed prior to the November 7 next following the giving of such written notice, this Agreement, together with the Basic Agreement and local supplements thereto shall terminate unless otherwise agreed upon.

4. In the event at any time the Basic Agreement and the local supplements thereto shall have been terminated as a result of the termination of this Agreement as provided in the preceding Paragraph 3 and the parties shall subsequently settle the issues involved in this Agreement which resulted in the termination thereof, the Basic Agreement and the local supplements thereto shall be immediately reinstated in full force and effect.

5. This Agreement may be amended by mutual agreement between the parties. If either party proposes amendments to this agreement during the life thereof, negotiations on such proposals shall begin within thirty (30) days. I[f] no settlement

is reached, the provisions of this Agreement shall continue in effect.

6. In the event that right, title or possession to any or all of the plants covered by this Agreement shall pass to any subsequent owner by merger, acquisition, sale, or any other method of disposition or acquisition. The benefits provide[d] in this Agreement shall be binding upon the Company and its successors and assigns.

EXHIBIT A

1993 PENSION PLAN

M&G POLYMERS, USA, LLC

* * *

Article II

ADMINISTRATION

1. The 1993 Pension Plan was adopted by the Company by action of its Board of Directors on December 18, 1992. The Company reserves the right by action of its Board of Directors to modify, alter or amend the Plan in any respect at any time or times or to terminate the Plan at any time subject to the limitations of Article X.

2. The Company has, as of November 1, 1999 executed a Pension Trust Agreement with Mellon Bank, as Trustee (hereinafter referred to as the "Trustee"), which Pension Trust Agreement, as from time to time amended, constitutes a part of the Plan. The Company reserves the right, by action of its Board of Directors to modify, alter or

amend the trust at any time or times in accordance with the terms of the Pension Trust Agreement subject to the limitations of Article X.

3. To provide funds for the payment of Pension and other benefits provided by the Plan, contributions will be made by the Company and other Employers to the Trustee at such time or times, and in such amounts, as the Company shall determine by action of its Board of Directors. Such contributions will be held by the Trustee as a Trust Fund and administered and distributed in accordance with all the terms and conditions of the Pension Trust Agreement.

4. Payment of pensions and other benefits under the Plan will be made out of the Trust Fund upon certification by the Pension Board. Pensions and other benefits provided by the Plan are to be paid only from the Trust Fund and only to the extent assets therein permit.

* * *

Article III

ELIGIBILITY FOR PENSIONS

1. Normal Retirement Pension.

Each Employee who retires from the service of an Employer, on or after May 1, 1997, shall be eligible for an immediate pension if, at the time of his retirement, such Employee has attained age 65, which age shall be his normal retirement age for all purposes of the Plan, with the exception that, if the case of an Employee hired on or after January 1, 1988 and on or after his attainment of

age 60, the date on which the Employee has attained 5 years of continuous service shall be his normal retirement age. Each Employee who has attained his normal retirement age, but who has not retired by the April 1 following the calendar year in which he attains age 70-1/2, for purposes of the Plan may, at the election of the Employee, be deemed to have retired during the March following the calendar year in which he attains age 70-1/2 and then retired, and, in the event of such an election, he shall be eligible for an immediate pension commencing on such April 1.

2. Disability Retirement Pension.

Each Employee who retires from the service of, an Employer, on or after the Effective Date by reason of having become permanently incapacitated through some unavoidable cause shall be eligible for an immediate pension if, at the time of his retirement, such Employee (a) has not attained normal retirement age, and (b) has completed at least 10 years of continuous service prior to his retirement. An Employee shall be deemed to be permanently incapacitated as the term "permanently incapacitated" is used herein only:

(a) If he has become totally disabled by bodily injury or disease so as to prevent him from being physically able to meet the job requirements of any job in his Employer's establishment, and

(b) If such total disability has continued for a period of five consecutive months and, in the opinion of a qualified physical designated

by the Pension Board, will presumably be permanent and continuous during the remainder of his life. If, nevertheless, such Employee furnishes medical evidence satisfactory to a qualified physician designated by the Pension board that the total disability results from a terminal illness that will result in death during the five months waiting period, such Employee's total disability will be deemed to have continued for five consecutive months.

Incapacity shall be deemed to have resulted from an unavoidable cause unless it (a) was contracted, suffered or incurred while the Employee was engaged in, or resulted from his having engaged in, a felonious criminal enterprise, or (b) resulted from his habitual drunkenness or addiction to narcotics, or (c) resulted from an international, self-inflicted injury. Permanent incapacity resulting from any of such enumerated causes, or permanent incapacity, resulting exclusively from military service, for which he receives a government pension, shall not entitle an Employee to a pension under this Paragraph 2.

3. Early Retirement Pension.

Each Employee who retires from the service of an Employer, on or after the Effective Date, shall be eligible for an immediate pension if, at the time of his retirement, such Employee has not attained normal retirement age and (a) has completed at least 30 years of continuous service prior to his retirement or (b) attained age 55 and

has completed at least 10 years of continuous service prior to his retirement, and (c) is not eligible for any other pension under the Plan, except a deferred vested pension based upon a prior period of continuous service.

4. Deferred Vested Pension.

Each Employee whose employment with an Employer is terminated on or after January 1, 1989, shall be eligible for a deferred vested pension, if at the time of the termination of his employment, such Employee (a) has not attained normal retirement age, (b) has completed at least 5 years of continuous service prior to his termination of employment, and (c) is not eligible for any other pension under the Plan except another deferred vested pension based upon a prior period of continuous service. However, if an Employee has met the eligibility requirements for a Service Award under Article XI, a Special Distribution under Article XII or a Separation Payment under Article XIII and if he elects to receive such a lump sum payment as provided therein, he shall not be eligible for a deferred vested pension.

* * *

An Employee on layoff with recall rights and who is recalled to work may make application for a Disability Pension under Paragraph 2 of this Article III if at the time of his recall he has not attained normal retirement age and has completed at least 10 years of continuous service prior to such layoff.

An Employee on layoff with recall rights who retires on pension under this Paragraph 6 after attainment of age 60 will have the amount of his pension calculated using the service credit (as determined by the Collective Bargaining Agreement which applies to him) that the Employee would have acquired had he been recalled on the day prior to his retirement.

Article IV

AMOUNT AND DURATION OF PENSIONS

* * *

7. Except as hereinafter provided, each pension shall be paid monthly. The commencement and duration of pensions shall be governed by the following provisions:

(a) The payment of a normal retirement pension shall commence during the month next following the month in which the Employee retires if application is made not later than the last day of the month following retirement; and, if application is made at a later date, such pension shall commence with the month in which application is made*. A normal retirement pension shall continue during the life of the Pensioner, and the last monthly payment of such pension shall be made for the month in which the death of the Pensioner occurs; provided, however, that if less than 60 monthly payments of such pension have then been made, such payments

shall continue after the Pensioner's death until a total of 60 monthly payments have been made. The normal retirement pension of an Employee who has attained age 70-1/2 and elects to be deemed to have retired and who continues to accrue a benefit after his normal retirement pension commences shall have his benefit adjusted January 1 of each year following the year in which such accrual is earned (an "accrual year"). The adjusted normal retirement pension shall be equal to the monthly benefit to which the Employee would have been entitled under Paragraph 1 of this Article IV if he had retired on December 31 of the accrual year, but based on any optional method of benefit payment and other factors in effect on the date he was deemed to have retired.

(b) The payment of a disability pension shall commence during the sixth month following the month in which the Employee's permanent incapacity occurred, if application is made not later than five months following the close of the month in which permanent incapacity occurred; and if application is made at a later date, such pension shall commence with the month in which application is made. A disability pension shall continue until the death of the Pensioner and the last monthly payment of such pension shall be made for the month in which the death of the Pensioner occurs; provided, however, that if the Pensioner's death occurs before 60 monthly payments of such pension have been made such payments shall continue

after the Pensioner's death until a total of 60 such monthly payments have been made.

(c) The payment of a deferred early retirement pension shall commence during the month next following the month in which the Employee attains age 62 if application is made not later than the last day of the month next following the month in which the Employee attains such age; and if application is made at a later date, such pension shall commence with the month in which application is made. No such application may be filed earlier than 60 days prior to the employee's 62nd birthday. In the case of any other early retirement pension, payment shall commence during the month next following the month in which the Employee retires if application is made not later than the last day of the month following retirement; and if application is made at a later date, such pension shall commence with the month in which application is made. Once an early retirement pension commences it shall continue until the death of the Pensioner and the last monthly payment of such pension shall be made for the month in which the death of the Pensioner occurs; provided, however, that if, at the death of the Pensioner less than 60 monthly payments of such pension have been made, such payments shall continue after the Pensioner's death until a total of 60 monthly payments have been made.

* * *

(e) The payment of a deferred vested pension, in the case of a former Employee who had at least 5 years of continuous service prior to his employment termination date, shall commence during the month next following the month in which the Employee attains normal retirement age if written application is made not later than the last day of the month next following the month in which the Employee attains such age; and if written application is made at a later date, such pension shall commence with the month in which written application is made or, if later, the month specified in such written application. In the case of a former Employee who had at least 10 years of continuous service prior to his employment termination date, the deferred vested pension may commence as early as age 55 consistent with the application provision set forth above. A deferred vested pension shall continue until the death of the Pensioner, and the last monthly payment of such pension shall be made for the month in which the death of the Pensioner occurs; provided, however, that if, at the date of the Pensioner who had at least 10 years of continuous service prior to his employment termination date and less than 60 monthly payments of such pension have been made, such payments shall continue after the Pensioner's death until a total of 60 monthly payments have been made.

* * *

(g) A pension payment due for the month of the death of the Pensioner or his Beneficiary which would otherwise be payable to such Pensioner or Beneficiary may be paid in the discretion of the Pension Board to any one, or jointly to any number, of the following surviving relatives of the person to whom such payment would otherwise be made, namely, wife, husband, mother, father, child or children, brother or brothers, sister or sisters.

* * *

Article VI

OPTIONAL METHODS OF PAYMENT

1. Upon filing written notice with the Pension Board at the time and under the conditions set forth in this Article, an Employee who retires on pension under Paragraph 1, Paragraph 2 or Paragraph 3 of Article III, on or after the Effective Date, shall have the Option, with spousal consent, to designate his spouse as his "Contingent Annuitant" or to designate any person as his "Beneficiary" and to provide, in lieu of the monthly pension otherwise payable after such Option becomes effective, reduced monthly payments in accordance with one of the following optional methods of payment, which shall be effective only with respect to the monthly pension otherwise payable after such Option becomes effective; provided, however, notwithstanding the election of Options A, B, or C, that no reduction in the monthly amount otherwise payable after such option becomes effective will be made until a total

of 60 monthly payments in the full amount have been made:

Option A

A reduced monthly pension payable to the Employee for his life, with the continuance of monthly payments in such reduced amount after his death to his Contingent Annuitant during the lifetime of his Contingent Annuitant and, if both the Employee and his Contingent Annuitant die before 60 monthly payments have been made after such Option becomes effective, with the continuance thereafter of monthly payments to the estate of the survivor of the Employee and his Contingent Annuitant, until a total of 60 monthly payments have been made.

Option B

A reduced monthly pension payable to the Employee for his life, with the continuance of monthly payments equal to one-half of such reduced amount after his death to his Contingent Annuitant during the lifetime of his Contingent Annuitant and, if both the Employee and his Contingent Annuitant die before 60 monthly payments have been made after such Option becomes effective, with the continuance thereafter of monthly payments to the estate of the survivor of the Employee and his Contingent Annuitant until a total of 60 such monthly payments have been made.

Option C

A reduced monthly pension payable to the Employee for his life, with the continuance to his Beneficiary of monthly payments in such reduced amount after his death for the remainder, if any, of the 10, 15 or 20 year term (as the Employee shall elect) immediately following the date on which such Option becomes effective, and with any such monthly payments remaining unpaid upon the death of the survivor of the Employee and his Beneficiary to be made to the estate of such survivor; provided, however, that no term may be elected that is in excess of the joint life expectancy of the Employee and his Beneficiary determined as of the date the Option becomes effective.

Option D

A reduced monthly pension payable to the Employee for his life, with the continuance of monthly payments in such reduced amount after his death to his Contingent Annuitant during the lifetime of his Contingent Annuitant and, if both the Employee and his Contingent Annuitant die before 60 monthly payments have been made after such option becomes effective, with the continuance thereafter of monthly payments to the estate of the survivor of the Employee and his Contingent Annuitant, until a total of 60 monthly payments have been made; provided, however, that if the Contingent Annuitant predeceases the Employee, no reduction in the monthly amount otherwise payable after this Option becomes effective will

be made with respect to monthly payments to the Employee after the death of the Contingent Annuitant.

Option E

A reduced monthly pension payable to the Employee for his life, with the continuance of monthly payments equal to one-half of such reduced amount after his death of his Contingent Annuitant during the lifetime of his Contingent Annuitant and, if both the Employee and his Contingent Annuitant die before 60 monthly payments have been made after such Option becomes effective, with the continuance thereafter of monthly payments to the estate of the survivor of the Employee and his Contingent Annuitant in an amount equal to the monthly amount paid under the Option to the last to survive of the Employee and his Continent Annuitant until a total of 60 such monthly payments have been made; provided, however, that if the Contingent Annuitant predeceases the Employee no reduction in the monthly amount otherwise payable after this Option becomes effective will be made with respect to monthly payments to the Employee after the death of the Contingent Annuitant.

* * *

Article IX

MISCELLANEOUS

* * *

6. Notwithstanding any other provision of the Plan, (i) an Employee's right to a normal retirement

benefit under the Plan shall be nonforfeitable upon and after his normal retirement age, and (ii) in the event of the termination or a partial termination of the Plan, the rights of all Employees who are affected by such termination to benefits accrued to the date of such termination, to the extent funded as of such date, shall be nonforfeitable.

* * *

10. Notwithstanding any other provision of the Plan to the contrary, if a benefit is payable under the Plan, then payment of an Employee's or former Employee's benefits shall not commence later than the April 1 following the later of (a) the calendar year in which the Employee attains age 70-1/2 or (b) except in the case of an Employee who is a 5-percent owner with respect to the Plan Year ending in the calendar year in which the Employee attains age 70-1/2, the calendar year in which the Employee retires; provided, however, that the required commencement date hereunder for an Employee who attained age 70-1/2 in 1988, who is not a five percent owner (as defined in Section 416 of the Code) at any time during the period of five Plan years ending in 1988, and who had not separated from service by January 1, 1989, shall be April 1, 1990. An Employee, other than a 5-percent owner, who has attained age 70-1/2 and has not retired but who has been deemed to have retired and has been receiving a pension may elect not to receive any further distributions from the Plan until not later than April 1 following the calendar year in which he retires. In the case of an Employee who retires in a calendar

year after the calendar year in which the Employee attains age 70-1/2 who does not commence receiving payment of benefits until the April 1 following the calendar year in which the Employee retires, the Employee's accrued benefit shall be actuarially increased to take into account the period after age 70-1/2 in which the Employee was not receiving any benefits under the Plan. In the event the retired or former Employee dies after payment of his pension has begun and if payment of his pension does not cease on his date of death, payment shall continue in accordance with the optional form of payment in effect at his date of death. In no event shall payment be less rapid than permitted by Section 401(a)(9) of the Code. In the event the retired or former Employee dies prior to commencement of any benefit to which he is entitled under the Plan, his entire benefit shall be paid within five years after the date of his death, unless such benefit is payable to a designated beneficiary, as defined in Section 401(a)(9) of the Code, for a period which does not exceed the life or life expectancy of such designated beneficiary, in which event distribution of such interest shall commence no later than the date the retired or former Employee would have attained age 70-1/2 if the designated beneficiary is the surviving spouse of such retired or former Employee, or the date which is one year after the date of such retired or former Employee's death if the designated beneficiary is not the surviving spouse of such retired or former Employee. In the event, an Employee fails to make written application for a pension or other benefit payable under the Plan, such application nevertheless

shall be presumed to have been made and pension payments shall commence.

* * *

Article X

LIMITATIONS ON AMENDMENT AND TERMINATION

No pension or other benefit granted prior to the time of any modification, alteration, amendment or termination of the Plan pursuant to Article II, or prior to the time of any withdrawal of an Employer pursuant to Article VII, shall be reduced, suspended or discontinued except as specifically provided in the Plan. In the event of Plan termination, the disposition of the Trust Fund shall be made for the exclusive benefit of Pensioners and employees of Employers as provided in the Pension Trust Agreement. Upon such termination of the Plan, the Pension Board and the Company shall continue to participate in the operation and administration of the Plan and the Trust Fund, with respect to pensions and other benefits granted prior to the time of such termination and with respect to the disposition and liquidation of the Trust Fund as provided in the Pension Trust Agreement.

* * *

3. Top Heavy Vesting

Except in cases where the applicable terms of the Plan in effect immediately prior to the effective date of operation of this Article XIV would be more favorable to the Employee, in the event the Plan is determined to be a top heavy plan, an

Employee's nonforfeitable right to a percentage of the accrued portion of his monthly normal retirement benefit shall be ascertained in accordance with the vesting schedule hereinafter set forth.

Vesting Schedule

Years of Service	Nonforfeitable Percentage
Less than 2 years	0%
2 years but less than 3 years	25%
3 years but less than 4 years	50%
4 years but less than 5 years	75%
5 years or more	100%

* * *

EXHIBIT B

COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS AND THE EMPLOYEE SAVINGS PLAN FOR BARGAINING UNIT EMPLOYEES

EXHIBIT B-1

M&G POLYMERS, LLC, USA COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS

Effective January 1, 1998, and for the duration of this Agreement thereafter, the Employer will provide the following program of hospital benefits, hospital-medical benefits, surgical benefits and prescription

drug benefits for eligible employees and their dependents, with the exception that none of the aforesaid benefits shall be applicable in the event of accident or sickness covered by a Workers' Compensation Act nor shall there be any duplication of benefits under any Employer-sponsored Program.

1. Benefits

(a) General

Benefits will be payable in accordance with the provisions of Paragraphs (b), (c), and (d) below, for eligible charges authorized by a doctor licensed to practice medicine which are reasonably necessary for the care and treatment of a non-occupational accident or illness of an Employee or eligible dependent.

(b) Amounts.

The benefits specified below will be payable with respect to eligible charges which are incurred during a benefit year, exclusive of the charges used to satisfy the deductible applicable to the benefit year.

(1) 85% (90% when care is received from a Select Provider) of all eligible charges incurred in connection with mental illness or functional nervous disorders of any type or cause other than charges incurred in connection with the administration of convulsive therapy and other than charges incurred during a confinement in a hospital for which room and board charge is made and only to the

extent that such charges are incurred in connection with the first fifty of such visits during a calendar year.

(2) 100% of eligible charges for out-patient surgery (including the facility charge).

(3) The physician's professional opinion charge for the Second Surgical Opinion is paid at 100%.

(4) 100% of eligible charges for Pre-Admission Testing (PAT) that is performed under an approved PAT program of the hospital in which surgery is to be performed.

(5) 85% (<u>90% when care is received from a Select Provider</u>) of all other eligible charges, exclusive of any charges with respect to which benefits are payable under subparagraphs (1), (2), (3) and (4) above.

(c) Deductible.

(1) The deductible applicable to a covered individual for each benefit year will be <u>$175</u>.

(2) The eligible charges used to satisfy the deductible applicable to a covered individual for a benefit year will be the first eligible charges incurred during the benefit year in an amount equal to the deductible.

(3) If at any time during a benefit year the deductible applicable to such benefit year is individually satisfied, in accordance with subparagraphs (1) and (2) above for

any three members of a family unit, or if the aggregate deductible amount for members of a family unit equals $350, the deductible applicable to all other members of a family unit for such benefit year shall also be considered to have been satisfied.

The term "family unit" as used herein shall mean an Employee, spouse, and eligible dependent children.

(d) Co-payment Maximum.

The co-payment maximum shall apply to those eligible expenses which are eligible to be reimbursed at 85% (90% when care is received from a Select Provider) as described in paragraphs 2 and 4 below. This maximum is a limit of $750 per covered individual or $1,100 per family per year, whichever shall first occur, on the amount of 15% (10% when care is received from a Select Provider) co-payments an individual or family must pay in a benefit year. Once this $750 individual or $1,100 family limit is reached in a benefit year, the Plan will pay 100% of those eligible expenses incurred during the remainder of that benefit year on behalf of such individual or family having met the aforementioned annual limit which would otherwise be eligible for 85% (90% when care is received from a Select Provider) payment.

Notwithstanding the above, any remaining days in a Convalescent Nursing Unit after the initial 100-day period of confinement will

continue to be reimbursed at 85% (90% when care is received from a Select Provider).

(e) Overall Benefit Maximum.

A lifetime maximum of $1,500,000 of benefits will be payable with respect to all charges incurred for all illnesses during the entire duration of coverage for any one covered individual.

2. Expenses Eligible For Benefits

(a) Hospital Expenses

(1) General

Charges for hospital confinement due to an accident or sickness which is approved by a doctor licensed to practice medicine will be considered eligible expenses. In no event however, will benefits be paid for rehabilitation treatment of drug addicts or alcoholics in a hospital, in a wing or section of a hospital or in a facility connected with a hospital.

(2) Categories of Eligible Expenses

Benefits are provided for the following eligible charges:

(i) For semi-private accommodations, the eligible charges will be equal to the hospital's daily charge for room and board for a semi-private room.

For private accommodations eligible charges will be based on the hospital's

average daily charge for room and board for a semi-private room.

Charges for room and board benefits will be eligible for reimbursement without any limit as to the maximum number of days except confinements for mental illness or functional nervous disorders of any type or cause will be limited to a maximum of 730 days for any one confinement. There will be no limit as to the number of these confinements for which benefits are paid if the confinements are due to a different cause or if separated by complete recovery.

This provision includes maternity benefits for female employees and wives of employees.

(ii) When there is a hospital charge for room and board, the following items will also be eligible for reimbursement: Miscellaneous hospital-medical services and supplies, administration of anesthesia, ambulance service provided by any hospital or professional ambulance service and charges made by hospital-approved physicians or other medical technicians for services utilizing hospital equipment, when such services are not provided by the hospital or performed by members of the hospital staff.

The term "miscellaneous hospital-medical services and supplies" shall include bandages, crutches, splints, braces and trusses (including services related to initial fitting and adjustment of these items) when provided by the hospital or other professional qualified personnel.

The term "miscellaneous hospital-medical services and supplies" shall also include hospital charges for "supplementary medical service", "room and board supplement", "special room supplement", "isolation", "contagious", "intensive care", "cardiac care unit", or similar terms of like meaning if such services are, in fact, so billed and certified by the hospital to be hospital-medical services and/or hospital-medical supplies.

(iii) Charges for visits during a hospital confinement by a doctor licensed to practice medicine will be considered eligible expenses.

(3) Hospital Admission Certification Provisions

Whenever benefits are provided in accordance with subparagraphs (1) or (2) above, the amount of any such benefit payable will be subject to hospital admission certification approval by the Utilization Review Firm. Certification

approval by the Utilization Review Firm will be required as follows:

(i) Non-emergency medical or surgical admission will require Pre-Admission Certification as to the need for confinement.

(ii) Emergency admission will require notification to the Utilization Review Firm within 48 hours after the admission (or if longer, on the first business day following a weekend or holiday admission) and certification approval as to length of stay. When an emergency admission confinement does not exceed 48 hours, certification approval by the Utilization Review Firm will not be required.

(iii) Certification approval of hospital confinement admission will require concurrent review certification as to the continued need for confinement and length of stay.

(iv) Pre-Admission Testing (PAT) under an approved PAT program at the hospital in which surgery is to be performed will be required on all non-emergency surgery.

When certification is required and the Utilization Review Firm does not grant such certification approval, the benefits otherwise payable in subparagraphs

(1) and (2) above, will be provided as follows:

(i) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for the weekend days of Friday or Saturday when a non-emergency admission occurs on such days unless surgery was performed on such weekend days of Friday, Saturday or Sunday or it was medically necessary for the patient to be admitted on the weekend days of Friday or Saturday.

(ii) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for the days of any admission where required certification was not obtained.

(iii) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charges for any days following the initial certification of a specified number of days for which certification approval was not obtained.

(iv) 75% (90% if the individual or family co-payment maximum is reached) of the hospital's daily charge for room and board for the first certified day of confinement when an approved Pre-Admission Testing (PAT) program was available at the hospital

and such PAT was not used unless due to medical reasons.

The required certification approvals described in this subparagraph will be made by a Physician Advisor of the Utilization Review Firm following a review and evaluation of medical information provided by the patient's attending physician or by the Utilization Review Firm using established medical criteria to determine medical necessity and appropriateness of the admission and proposed plan of treatment. If the patient's attending physician and the Utilization Review Firm's Physician Advisor are unable to reach agreement concerning the patient's need for hospital confinement or continued confinement, the need for such confinement will be decided by a "local panel" physician.

(b) Post-Hospital Expenses

(1) Convalescent Nursing Unit Care

(i) Charges made by an approved Convalescent Nursing Unit for room and board and other services and supplies for medical care, exclusive of professional services, will be considered eligible expenses provided the Employee or dependent has been confined in a hospital for at least 3 days and then admitted to such Convalescent Nursing Unit within 21 days following the hospital confinement

for the same condition that required hospital confinement and upon the written recommendation of the attending physician certifying that the patient's condition would require continued hospital confinement if Convalescent Nursing Unit care were not available. Re-admission, upon the attending physician's recertification, to such Convalescent Nursing Unit within 14 days following discharge will be considered a continuation of the same confinement for purposes of this Paragraph (a).

(ii) Eligible charges for all such services will be the charges actually made by the Convalescent Nursing Unit. Such allowance shall be paid only while the patient remains under the continuous care of the attending physician and only so long as the attending physician certifies that twenty-four hour a day nursing care is essential to the patient's health.

Convalescent Nursing Unit charges shall be eligible for reimbursement up to a maximum of 730 days of confinement in a Convalescent Nursing Unit reduced by the number of days of confinement in a hospital.

(iii) The term "Convalescent Nursing Unit" means a licensed institution approved by the Social Security

Administration pursuant to Title XVIII (Health Insurance for the Aged) of the Social Security Act, as amended in 1965. The term "Convalescent Nursing Unit" shall also include those institutions listed as "Extended Care Facilities["] in the list titled "Accredited Extended Care Facilities" issued by the Joint Commission on Accreditation of Hospitals as it may be amended from time to time. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, or as a facility for the aged or for the care of drug addicts or alcoholics.

(2) Visiting Nurse Service

Charges will be considered eligible expenses for reimbursement when an employee or dependent receives medical treatment in his home by a Registered Nurse (RN) or a Licensed Physical Therapist employed regularly by an approved Visiting Nurse Service, immediately following and for the same cause which required a confinement in a hospital for at least 3 days, when ordered in writing by the attending physician.

The allowance for Visiting Nurse Service charges shall be the standard charge of the Visiting Nurse Service for each day such services are rendered to a maximum

of 100 days for any one cause during any calendar year. Such allowance shall be paid only so long as the attending physician certifies such medical treatment to be necessary.

The term "Visiting Nurse Service", as used herein, means an organization or agency which meets all of the following requirements:

(i) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services,

(ii) Its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse to govern the services provided,

(iii) It provides for full-time supervision of such services by a registered nurse and has an administrator, and

(iv) It maintains a complete medical record on each patient.

(c) Outpatient Treatment And Diagnostic Expenses

(1) Charges directly connected with x-rays (except routine dental x-rays) or

fluoroscopy for diagnostic purposes will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine, or a doctor of surgical chiropody.

Notwithstanding the above procedures done for diagnostic purposes in the event of accident or illness, charges will also be paid for:

(i) routine PAP test,

(ii) routine mammogram performed annually upon the attainment of age 40.

(2) Charges made for diagnostic laboratory tests will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine.

(3) Charges made for such medical tests as basal metabolism, electrocardiographs and electroencephalograms will be eligible for reimbursement wherever performed when authorized by a doctor licensed to practice medicine.

(4) Charges made by a hospital for necessary medical care performed in the hospital's emergency or outpatient department for treatment of a physical disorder when authorized by a doctor licensed to practice medicine shall be eligible for reimbursement. Such medical care shall include all the hospital-medical services and supplies and other charges described in paragraph 2(a)(2)(ii).

(5) Charges made by a hospital will also be eligible for reimbursement when there is no hospital charge for room and board if the Employee or his dependent receives electro-shock therapy in a hospital or is confined in a hospital either for an operation or for emergency care following an accident (including removal, wherever performed, of sutures, clamps, or casts applied for treatment of injuries sustained in such accident).

(6) Other charges eligible for reimbursement will include:

(i) Charges made by a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) for emergency are rendered in a medical facility (other than a hospital) or in a physician's office following an accident.

(ii) Charges made for a physician's services for medical care and treatment, surgery and acupuncture, excluding dental services.

(d) Surgical Expenses

(1) Surgical Services

Charges for surgical services consisting of operative and cutting procedures (including the usual post-operative care) arising from an accident or sickness not covered by a Workers' Compensation Act will be eligible for reimbursement. Such services may be performed in or out of a

hospital by a doctor licensed to practice medicine[. O]ther charges eligible for reimbursement will include:

(i) Surgical services performed by a doctor of surgical chiropody (D.S.C.) acting within the scope of his license, which are described in the Schedule of Surgical Operations—Chiropody (made a part hereof by reference).

(ii) Obstetrical services, including necessary prenatal and postnatal ca[r]e, for pregnancies of female Employees and wives of Employees.

(iii) Non-operative procedures performed in lieu of surgery by a doctor licensed to practice medicine which are described in the "Schedule of Miscellaneous Specific Therapeutic Procedures" (made a part hereof by reference).

(iv) The administration of anesthetics, except local infiltration anesthetic, in connection with surgical or obstetrical services for which benefits are provided under the Program, when administered and billed by a doctor licensed to practice medicine, other than the operating surgeon or his assistant.

(v) When the surgical services are performed in a hospital, charges for the services of a doctor licensed to

practice medicine who actively assists the operating surgeon in the performance of such surgical services when the type and complexity of the surgical services and the condition of the patient requires such assistance will be eligible for reimbursement.

(vi) Organ transplants when coordinated by the Network Administrator in an approved network transplant facility. Benefits will be payable at 100% of the eligible charges and will not be subject to the deductible and co-payment provisions described in Paragraph 1. Organ donors will also be covered in the network when the recipient is covered for hospital, surgical and medical benefits under this Exhibit B-1. Reasonable travel and lodging expenses for the patient; the patient's spouse or family member and an eligible organ donor will be paid up to a total of $10,000.

If employees and eligible dependents do not have organ transplants coordinated by the Network Administrator in a network facility, benefits under this Exhibit B-1 will be limited to only eligible charges, subject to the deductible and co-payment provisions described in Paragraph 1, up to the amount that would have been paid if the transplant was

done in a network facility. However, travel and lodging expenses will not be included or paid.

(2) Second Surgical Opinions

Charges made for a second surgical opinion in connection with a non-emergency surgical procedure will be eligible for reimbursement. A non-emergency surgical procedure is defined as a procedure which may be scheduled at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

(e) Other Eligible Expenses

Charges actually made to the Employee or eligible dependent on account of their illness for service, treatment, and supplies ordered by a physician as described in this Paragraph (e) will be considered eligible expenses.

(1) Local ambulance service.

(2) Physician's services for medical care and treatment, surgery and acupuncture, excluding dental services.

(3) Private duty professional nursing services rendered by a registered nurse or a licensed practical nurse other than a close relative or a nurse who ordinarily resides in the Employee's home.

* * *

(8) The first routine hospital visit to a newborn child by a physician.

3. Exclusions and Ineligible Expenses

Eligible expenses will not include any of the following:

(a) Charges incurred in the event of an accident or sickness covered by a Workers' Compensation Act or similar legislation.

(b) Charges for eye refractions or examinations for the fitting of glasses or hearing aids.

(c) Charges for medical examinations of a covered individual for "check-up" purposes when not incident and necessary to the treatment of an illness.

(d) Charges incurred in connection with remedying a condition by means of cosmetic surgery unless such condition is the result of accidental bodily injuries sustained while a covered individual.

(e) Charges incurred during confinement in a hospital owned or operated by the United States Government or any agency thereof, charges for services, treatments or supplies furnished by or for the United States Government or any agency thereof, and charges incurred during confinement in a hospital owned or operated by a State, Province or political subdivision unless there is an unconditional requirement to pay these last mentioned charges without regard to any

rights against others, contractual or otherwise.

(f) Charges for physicians' services in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, including treatment for temporomandibular joint (TMJ) dysfunction.

(g) Charges for physicians' services in connection with weak, strained or flat foot, any instability or imbalance of the foot, or any metatarsalgia or bunion; unless the charges are for an open cutting operation or for services prescribed by a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

(h) Charges for physicians' services in connection with corns, calluses or toenails; unless the charges are for the partial or complete removal of nail roots or for services prescribed by a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is treating the patient for a metabolic or peripheralvascular disease.

(i) Charges incurred for services, treatments and supplies in connection with an illness of a covered individual, to the extent to which such services, treatments and supplies, or payment of such charges, or any benefit for or in connection with such charges, services, treatments or supplies, is provided for the covered individual under or by any law or plan of any government or political subdivision,

including Medicare, or any other plan which you participate by virtue of your employment with the Employer.

If, after benefits have been paid on account of services, treatments and supplies given to the Employee or eligible dependent in connection with an illness of such person, it is determined that any such services, treatments or supplies have been provided from any source referred to above, the Employer will be entitled to a refund from the Employee of the amount paid by it in connection with such illness which is in excess of the benefits which would have been payable based on the actual eligible charges incurred.

(j) Expenses incurred for private room accommodations which are in excess of the hospital's daily charge for a semi-private room.

(k) Services, supplies, and treatment prescribed by someone other than a physician.

(l) Services or supplies of common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, blood pressure kits, or supplies of a similar nature, even if prescribed by a physician.

(m) Custodial care, including accommodations, professional services, and nursing services needed only for daily living, not for the treatment of an illness or injury.

(n) Services or supplies for training or education, such as prenatal classes, diabetic training, etc., or for learning disabilities.

(o) Services provided by a member of your immediate family.

(p) Services or supplies provided by a sanitarium.

(q) Rest cures, travel, recreation or physician directed diversional therapy.

(r) Hospitalization for environmental change or charges connected with prescribing such a change.

(s) Private duty nursing for custodial purposes.

(t) Charges incurred for prescription drug expenses in excess of the Plan allowance.

(u) Research studies and screening exams.

(v) Respiratory/inhalation therapy in an outpatient facility unless performed as part of the treatment for an accident, illness, or surgery resulting from an emergency.

(w) Services or supplies used to treat conditions related to autism, hyperkinetic syndromes, learning disabilities, discipline problems or mental retardation, except to diagnose the condition.

(x) Sterilization reversals.

* * *

during a visit to a duly licensed Chiropractor (D.C.) or a Doctor of Osteopathy (D.O.) practicing within the scope of their license, subject to a maximum of 30 visits per calendar year per individual will be considered eligible expenses.

(b) Charges incurred for x-rays made during any such visit when necessary for the diagnosis and analysis of such neuromusculoskeletal condition will be considered eligible expenses for reimbursement. The maximum benefit for all such x-rays arising out of the same condition will be $100 for each Employee or dependent of an Employee during a calendar year.

5. Prescription Drug Benefits

(a) General

Prescription drug payments will be made if an Employee or Dependant, as a result of an accident or sickness, incurs expenses for covered prescription drugs dispensed by any person or organization legally licensed to dispense drugs, upon the order of a physician licensed to practice medicine.

(b) Benefits

(1) Benefits will be provided through participating providers who have agreed to accept an assignment of the benefit claim hereunder by the Employee to the provider plus a co-payment by the Employee or Dependent of $4.00 for the generic medication or $10.00 for name

brand drugs as full payment for the covered prescription drug. The co-payment amount herein is to be paid by the Employee or his Department and is applicable to each separate prescription order and to each refill thereof.

(2) Maintenance drug requirements may be filled through the Mail-Order Prescription Service established by the Company in which case the co-payments contained in Paragraph (b)(i) above will be reduced to $2.00. If a physician authorizes a generic medication to be dispensed and the patient insists on a name brand drug, the reimbursement under the Mail-Order Prescription Service shall be limited to the amount payable as if the generic drug has been dispensed.

(3) If a covered prescription drug is dispensed by a non-participation provider, the amount of the benefit for each separate prescription order and each refill thereof will be:

(i) The dispensing fee for the covered prescription drug which the individual provider most frequently charges his customers for dispensing similar drugs, plus

(ii) the actual cost of the covered prescription drug to the provider, plus

(iii) any applicable state sales tax for the covered prescription drug, less

(iv) $4.00 for generic medication or $10.00 for name brand drugs.

(4) If a prescription is filled outside of the Mail-Order Prescription Service and if a name brand drug is dispensed in lieu of a generic equivalent drug which has been approved for inclusion in the Maximum Allowable Cost (MAC) list by the Network Administrator the reimbursement will be limited to the amount payable as if the generic drug had been dispensed.

(c) Covered Prescription Drugs

The prescription drugs covered by this paragraph are:

(1) Injectable insulin, or any Prescription Legend Drug for which a prescription is required;

(2) A compound medication of which at least one ingredient is a Prescription Drug; and

(3) Any other drug which under the applicable state law may be dispensed only upon the prescription of a physician:

Provided that a prescription drug shall not be covered under this Paragraph if (i) the cost thereof is included in the cost of other services or supplies provided to or prescribed for the Employee or his dependent or (ii) such drug is consumed at the time and place the prescription is ordered; except, however, a drug

dispensed by a licensed pharmacy doing business with the public will be covered.

"Prescription Legend Drug" means for the purpose of this Paragraph, any medical substance, the label of which, under the Federal Food, Drug, and Cosmetic Act, as from time to time amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription".

(d) Exclusions

(1) No benefit shall be payable to an Employee or his Dependent if he is entitled to received reimbursement under any Workers[ ] Compensation Laws or is entitled to benefits from any municipal, state, federal or other-governmental program of any sort.

(2) No benefit shall be payable for any medication or device which is to be used for contraceptive purposes, or for any therapeutic device or appliance (e.g., hypodermic needles, syringes, support garments and other non-medicinal substances).

(3) No benefits shall be payable for the administration of any medication.

(4) When a prescription drug is dispensed through a participating provider, no benefit shall be payable for any medication for which the customary and usual charge

is less than $4.00 for generic medication or $10.00 for name brand drugs.

*

(5) No benefit shall be payable for more than a 100-day supply of any medication through the Mail-Order-Prescription Service (30-day supply outside of the Mail-Order Prescription Service), for any refill in excess of the number specified by the physician, or for any refill dispensed after one year from the physician's order.

(6) No benefit shall be payable for any drug defined in paragraph (c) above, the reimbursement for which is considered taxable income by the [I]nternal Revenue Service.

(e) In addition to the benefits otherwise provided, herein, the Company may make available to Employees a mail order option.

(f) The eligible charges payable herein by the Employee will not be included for purposes of meeting the deductible nor will they apply towards the co-payment maximum.

6. Eligibility for Benefits under Exhibit B-1

(a) Active Employees who have elected the benefits provided under Exhibit B, will be covered by the provisions of this Exhibit B-1 on that Effective Date Employees not actively at work on the Effective Date, will be covered by the provisions of this Exhibit B-1 immediately

upon their return to work, but until such return to work, will have such coverage for hospital expense, surgical, hospital-medical and prescription drug benefits, if any, and for such period of time as is provided for them in the plan in effect prior to the Effective Date.

The foregoing shall not be construed to exclude Employees from coverage who are on vacation, leave of absence for Union activities, working less than their standard shift, or not actively at work because of a temporary disability.

(b) Employees hired after the Effective Date who elect the benefits provided under Exhibit B-1, will become covered by the provisions of this Exhibit B-1 on the 31st day of employment.

(c) Coverage for an Employee's dependents will become effective on the same date as the Employee's cover except that if a dependent, other than a new-born or a child placed for adoption with the Employee, of an Employee hired after the Effective Date, is confined in a hospital when the coverage for that dependent would otherwise become effective, the coverage will become effective upon final discharge from the hospital.

(d) An Employee's dependents are:

(i) The spouse, and unmarried children of the Employee under 19 years of age. A spouse becomes an Employee's dependent on the date of marriage to the

Employee. An unmarried child becomes an Employee's dependent on the later of:

the child's date of birth, or

the date of the Employee's marriage, in the case of a child acquired by marriage, or

the date of adoption of the child, or, if earlier, the date the child is placed with the employee for adoption and the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Eligibility as a dependent for a child placed with the Employee for adoption terminates upon the termination of the legal obligation of the Employee for total or partial support of the child.

(ii) Unmarried children of the Employee who are eligible as dependents may continue to be deemed eligible dependents of the Employee beyond age 19 provided such children upon attainment of age 19 are both dependent upon the Employee, as determined by the Employer, and are either:

mentally or physically incapable of self-support, or

full-time students, at an accredited high school, college or similar institution of higher education in a course

of study leading to a high school diploma, an Associate degree, a Bachelor's degree or a higher degree.

Extended eligibility as a dependent beyond age 19 will terminate when the Employee's child is:

no longer mentally or physically incapable of self-support as a result of the disability which gave rise to the original extension of coverage, or no longer a full-time student, or attains age 27, if earlier. In the case of a full-time student, the child who attains age 19 or ceases to be a full-time student, may again be deemed to be an eligible dependent as a full-time student if the child otherwise meets the requirements of this Paragraph (d)(ii) and, within 24 months following the date the child ceased to be a full-time student, requalifies as a full-time student.

Eligibility will also be extended to a child who was covered as a full-time student following the attainment of age 19 and while covered as a full-time student becomes disabled as herein defined. However, such eligibility will not be extended beyond the attainment of age 27.

(iii) The donor of an organ for transplant, when the recipient is covered for hospital, surgical, and medical

benefits under this Exhibit B-1 shall also be covered for such benefits as though the donor were a covered dependent child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor.

The word "child" in addition to the Employee's own children includes such stepchildren, foster children or other children (all unmarried) who live with the Employee and depend upon him for support and maintenance.

If any Employee acquires a child dependent other than by birth, legal adoption, placement for adoption, or marriage, such dependent shall not become eligible until three months have lapsed from the date such child was added to the Employee's enrollment record.

The term "unmarried children" means children who have never been married. When a dependent child becomes married, even though the marriage may later be dissolved, such child ceases to be an eligible dependent, forever.

7. Layoff

(a) In the event of layoff, coverage under this Exhibit B-1 will be continued without cost to the Employee for 90 days following layoff.

(b) Thereafter, coverage will be continued without cost to the Employee for a period during which he is laid off for one of the reasons set forth in Article I, Section 4(a) of the M&G Polymers Supplemental Unemployment Benefits Plan maintained by the parties hereto under Agreement as amended on April 26, 1973 and with respect to which he receives no earnings for work performed for the Employer; but the maximum period of such continued coverage shall be determined in accordance with the following table:

Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day Worked Prior to Layoff Would Entitle Him	Maximum Number of Months for which the Comprehensive Medical Benefits Plan Coverage will be Continued Without cost to Employee
16-19	1
20-23	2
24-27	3
28-31	4
32-35	5
36-39	6
40-43	7
44-47	8
48-52	9

(i) In applying the above table, the "Maximum Number of Full Weekly SUB Benefits to which Employee's Credit Units as of Last Day worked Prior to Layoff Would Entitle Him" shall be determined by dividing the number of the Employee's

Credit Units under the Supplemental Unemployment Benefits Plan by the number of credit Units to be cancelled for one SUB Benefit in accordance with the Credit Unit Cancellation table continued in Article III, Section 4 of such Supplemental Unemployment Benefits Plan, based on the Employee's seniority and the Trust Fund Position in effect as of the last day worked prior to layoff. The "Maximum Number of Months for Which the Comprehensive Medical Benefits Plan Coverage will be Continued Without Cost to Employee" shall commence with the 91st day of layoff.

(ii) With respect to any period of continuous layoff, changes in an Employee's Credit Units, Seniority or Trust Fund Position subsequent to the date layoff begins shall not change the number of months of continued coverage for which such Employee is eligible.

(iii) In the event that the aforesaid M&G Polymers Supplemental Unemployment Benefits Plan shall be terminated in accordance with its terms prior to the termination of the Agreement, Subparagraph (b) of this Paragraph 7 shall thereupon cease to have any force or effect.

(iv) The foregoing provisions of the Subparagraph (b) shall be subject to the Employer obtaining and retaining from

the Commissioner of Internal Revenue and from the United States Department of Labor the rulings referred to in the Agreement between the parties of April 26, 1973 relating to Supplemental Unemployment Benefits, and shall be effective with respect to layoffs commencing on or after the first day of the month following the month in which such rulings are received by the Employer. Pending receipt of said rulings, the foregoing provisions of this Subparagraph (b) will nevertheless be made operative as to any Employee for a period up to 90 days.

(c) The maximum period of coverage under this Paragraph 7 shall be 24 consecutive months following the month in which the Employee was laid off. For any month in this period not covered by Employer-furnished coverage, the Employee may continue the coverage by payment in advance at the Group Rate if arranged for prior to the expiration of such Employer-furnished coverage.

(d) An Employee on layoff may not continue coverage as provided in Subparagraphs (b) or (c) above while covered by any other employer-furnished hospital, medical and surgical benefit program; however, when the Employee ceases to be covered by any such other program, the Employee may then resume coverage hereunder for the remainder of the 24-month maximum period. In order to remain eligible for continued coverage as

provided in Subparagraphs (b) and (c) above, the Employee must maintain such coverage continuously except as provided above in this Subparagraph (d).

(e) Employees re-employed with credit for prior service will have an immediate reinstatement of coverage.

(f) An Employee on layoff eligible for coverage under this Paragraph 7 upon acceptance of any benefit payable under Article XIII of the 1950 Pension Plan shall be deemed to have terminated his employment with the Company and shall be deemed to have forfeited any and all remaining eligibility for coverages under this Paragraph 7.

8. Leave of Absence, Etc.

(a) During authorized leave of absence, (Other than leaves for which coverage is provided in Subparagraphs (b), (c) and (d) below), coverage under this Exhibit B-1 will be continued for a period not to exceed 90 days. Employees on leave of absence extending beyond such 90-day period may, by application to the Employer during such period and advance payment of current group rate premium, continue such coverage during the period of such leave of absence. An Employee who leaves the employ of the Employer as the result of being elected or appointed to public office or to an office in a Local Union cooperative enterprise serving Company employees may, by application to the Employer prior to leaving his employment with the Employer and upon

advance payment of the current group rate premium, continue such coverage during the period of his service in such office.

(b) During an authorized leave of absence for active duty in the Armed Forces for a period of less than six months, an Employee (and his eligible dependents) shall continue to be eligible for the benefits provided in this Exhibit B-1 to the extent that such benefits are not provided by the Military Service or the Federal or State Government.

(c) During an authorized leave of absence for pregnancy, Employees (and their eligible dependents) will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

(d) Notwithstanding the foregoing, coverage shall be continued without cost to the Employee during the period of an Employee's authorized leave of absence granted by his Employer for service with a local Union in an official or representative capacity or while representing such local Union in a State, County, or City council of AFL-CIO-CLC.

9. Injury or Sickness

Employees off work due to injury or sickness will continue to be covered subject to the provisions of this Exhibit B-1, during the period in which they accumulate seniority.

10. Termination of Coverage Under Exhibit B-1.

Except as described in Paragraphs 7, 8, and 9 immediately above, all coverage will terminate when active employment with the Employer terminates except as follows:

(a) The hospital, surgical, hospital-medical and prescription drug benefits for an Employee or dependent will be extended for three months following termination of coverage to cover a hospital confinement, an operation or obstetrical procedure resulting from a continuous total disability which began while the coverage was in force.

(b) Coverage will be extended for six months for the spouse and dependent children of an Employee who dies while on the payroll of the Employer, while on sick leave (and accumulating seniority), while on layoff with Exhibit B-1 coverage provided continuously under Paragraph 7 of this Exhibit B-1, during authorized leave of absence for a period not to exceed 90 days, or while on authorized leave of absence for service with a Local Union in an official or representative capacity.

The surviving spouse of a deceased Employee who is not eligible for continued coverage under Paragraph 12(b) of this Exhibit B-1 may elect, within such six months, to extend such coverage for up to an additional 18 months by payment in advance of the current group rate premium. Such spouse may make arrangements for the premium to be paid (i) in a lump sum amount equal to 14

monthly payments which may be deducted from any benefits the spouse is entitled to receive under Section A, Life Insurance or (ii) in quarterly installments paid directly to the Company.

(c) Coverage for an unmarried full-time student will be extended for 90 days following termination of status as full-time student provided no other group medical coverage of any kind is in effect on such student.

(d) Where practicable the Employer will arrange with insurance company for issuance of individual policies of medical expense benefits without medical examination when elected by an individual whose coverage terminates as provided in Paragraphs 7, 8, 9 and this Paragraph 10 or with respect to a child who no longer meets the eligibility requirements of this Exhibit B-1. Issuance of such an individual policy will be subject to the following:

(i) the Employee has been covered for 3 or more months under Exhibit B-1, and

(ii) a written application and payment of the first 3 months premium is made within 31 days following termination of coverage under Exhibit B-1, and

(iii) the individual policy will be one of the policies issued by the insurance company for conversion purposes and subject to the terms and conditions of said policy.

11. Employees Retired on Pension

*

*Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension under the 1993 Pension Plan (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1993 Pension Plan) whose full years of attained age and full years of attained continuous service (as defined in Article I of the 1993 Pension Plan) at the time of retirement equals 95 or more points will receive a full Company contribution towards the cost of the benefits described in this Exhibit B-1; provided, however, that each Employee eligible under the 1993 Pension Plan for a deferred vested pension whose employment with the Employer is terminated during or subsequent to the month in which he attained age 60 shall also received such benefits effective as of the first day of the month for which he receives a deferred vested pension. An Employee earns one point for each year of attained age and one point for each year of attained continuous service. Total points are derived by adding together the attained age and attained continuous service points. Employees who have less than 95 points at the time of retirement will receive a reduced Company contribution. The Company contribution will be reduced by 2% for every point less than 95. Employees will be required to pay the balance of the health care contribution, as estimated by the Company annually in advance, for the benefits described in this Exhibit B-1. Failure to pay

the required medical contribution will result in cancellation of coverage.

An Employee who retires with thirty (30) or more years of continuous service at any age will receive 95 points at retirement.

An Employee who retires with a disability pension with ten (10) or more years of continuous service will receive an additional 30 points at retirement.

An Employee who does not preferentially hire and subsequently retires as a result of a plant closure will receive an additional 25 points at retirement.

An Employee who, on January 1, 1996 is:

(a) Age 50 or older and has 10 or more years of continuous services but less than 30; or

(b) Any age and has 20 or more years of continuous service but less than 30;

will receive an additional 15 points which will be added to the Employee's point total at the time of their retirement.

After the date of the Employee's retirement, the deductible of this Exhibit B-1 shall be limited to $175 per person, $350 per family and the co-payment maximum shall be limited to $500 a year.

As an alternative to the above, an Employee required to make the described health care contribution may elect, at the time of retirement, a catastrophic medical plan option based on

the benefits described in this Exhibit B-1. The deductible under this option shall be $1,000 per covered individual per year, $2,000 per family per year, 80% Company co-payment, 20% retiree co-payment and a retiree co-payment maximum (after the deductible is satisfied) of $1,000 per covered individual or $1,500 per family per year. There is no health care contribution required for this option.

A retired employee required to make a health care contribution as described above shall be afforded the opportunity to change his medical plan option election in the event there is a change in the amount of the retiree medical contribution required or there is a change in the plan design.

12. Survivor Benefits

(a) The surviving spouse of (i) a deceased Employee who retires on or after the Effective Date, and was eligible for and receiving a monthly pension (other than a deferred vested pension or any benefit under Articles XI, XII or XIII of the 1993 Pension Plan); and (ii) a former Employee whose employment was terminated on or after the Effective Date, at or after attainment of age 60 and who dies after he has commenced to receive a deferred vested pension, shall be entitled to continue to receive the benefits of this Exhibit B-1 until death or remarriage under the exact same conditions and amounts that such surviving spouse was entitled to such benefits as a dependent immediately prior to the death of such deceased former Employee,

provided such surviving spouse was either an eligible spouse at the time of the Employee's retirement or had been legally married to the Employee for at least 12 consecutive months preceding his death.

Also, the surviving dependent of an Employee who is retired by the Employer and receiving a monthly pension (other than a deferred vested pension or any benefit payable under Articles XI, XII or XIII of the 1993 Pension Plan) on or after the Effective Date, provided such dependent as of the date of the death of such retired Employee was covered by these benefits as an eligible dependent, shall continue to be eligible to receive the exact same benefits and under the same conditions. Such coverage shall terminate when the surviving spouse remarries, provided further that such coverage shall continue after the death of spouse (if spouse has not remarried), so long as the dependent continues to qualify as such (but for being dependent on the Employee) and provided such surviving dependent was either an eligible dependent at the time of the Employee's retirement or was also a dependent of a surviving spouse who had been legally married to the Employee for at least 12 consecutive months preceding his death.

(b) The benefits provided under this Exhibit B-1 shall continue for the spouse and dependents of an Employee who had (i) attained age 55 or more and had 10 or more years of continuous service or (ii) 20 or more years of

continuous service, and who dies and at the date of death was eligible for said benefits, was on the payroll of the Employer, was on sick leave (and accumulating seniority), was on layoff with Exhibit B-1 coverage provided continuously under Paragraph 7 of this Exhibit B-1, was on authorized leave of absence for period not to exceed 90 days, or was on authorized leave of absence for service with a Local Union in an official or representative capacity. Such coverage shall terminate when spouse remarries or dies; provided that such coverage for each dependent shall continue after the death of the spouse (if the spouse has not remarried) so long as the dependent continues to qualify as such (but for being dependent on the Employee) under (i) or (ii) of Paragraph 6(d) of this Exhibit B-1.

In the event there is no surviving spouse as described above, such coverage shall also continue for a surviving dependent provided such surviving dependent was an eligible dependent at the time of the Employee's death and continues to qualify as such (but for being dependent on the Employee) under (i) or (ii) of Paragraph 6(d) of this Exhibit B-1.

13. Special Medicare Benefit

(a) Eligibility for Benefit

An Employee, Pensioner or eligible Surviving Spouse, and their eligible dependents, who are eligible for benefits under this Exhibit B-1 will be eligible for a Special Medicare Benefit upon (i) the Employee's retirement when

retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, when first eligible to enroll in Part B of Medicare with Medicare as primary coverage, provided the individual enrolls and continues to be enrolled in Part B of Medicare.

(b) Amount of Benefit

The amount of the Special Medicare Benefit will be equal to the lesser of the standard monthly premium for Part B of Medicare or $50.00 that is paid by persons who enroll when first eligible for primary Medicare coverage but shall not include any additional premiums such as those charged for delinquent enrollment.

Notwithstanding the above, the Special Medicare Benefit for any person who enrolls and continues enrolled in a Medicare Risk HMO under the provisions of Exhibit B-1, Paragraph 15 will be equal to the standard monthly premium for Part B of Medicare.

(c) Payment of Benefit

The Special Medicare Benefit will be paid to the Employee, Pensioner or eligible Surviving Spouse. Payment of the Special Medicare Benefit will commence on the first day of the month following (i) the Employee's retirement when retirement is after age 65, (ii) the attainment of age 65 when retirement is prior to age 65, or (iii) if earlier, the first day of the month following the month for which

such individual is eligible to enroll in Part B of Medicare with Medicare as primary coverage, provided the individual enrolls in Part B of Medicare.

Payment of the Special Medicare Benefit shall continue so long as the Employee, Pensioner or eligible Surviving Spouse and the eligible dependents continue to be covered for benefits under this Exhibit B-1 and continue to be enrolled for coverage under Part B of Medicare.

The Special Medicare Benefit will not be paid for any eligible dependent who is also eligible for this Special Medicare Benefit as an Employee, Pensioner or Surviving Spouse or when such dependent is reimbursed by another employer for the Medicare Part B premium. When a dependent child is covered by this Paragraph under more than one Employee or Pensioner, the Special Medicare Benefit will be paid only to the male Employee or Pensioner.

* * *

LETTER #1

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

Reference is made to the Pension, Insurance and Service Award Agreement between us dated May 9, 1997.

Notwithstanding the termination of said Agreement in accordance with its terms, the benefit programs provided for therein shall be continued for a period of ninety (90) days following such termination.

Sincerely yours,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated July 24, 1967
from Nelson G Ball to Kenneth Oldham)

LETTER #2

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

Reference is made to the "Reasonable and Customary Fee" contained in Exhibit B-1 of the Pension, Insurance and Service Award Agreement of May 9, 1997.

In administering this provision of the Agreement the "customary and reasonable fees" provided for therein shall be considered to extend to all procedures formerly covered by the "Surgical Schedule" and "Sub-Schedules" incorporated by reference in the Pension, Insurance and Service Award Agreement of 1964.

Further, if any Employee (for himself or his dependent) incurs a charge for a covered surgical, oral or podiatry service performed by a "Doctor" in excess of a "customary and reasonable" level and claim is made against him with respect to it, then, in the absence of agreement to or ratification of such charge by the Employee or his dependent the insurance carrier shall, at its own cost and expense, defend such claim and indemnify the Employee against liability thereon, provided the Employee and his dependent give prompt notice of the claim to the Company, tender defense of the claim to the carrier and cooperate fully with it in the defense of the claim.

Sincerely yours,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated July 24, 1967
from Nelson G Ball to Kenneth Oldham)

LETTER #3

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

In reference to the Pension, Insurance and Service Award Agreement dated May 9, 1997 the Company confirms the interpretations or practices as explained below:

1. Group Life Insurance

   If the group life and accidental death and dismemberment insurance of any employee covered by the aforesaid Agreement exceeded $4,500 immediately prior to August 1, 1964, then upon his retirement or attaining age 65, whichever is

earlier, we will reduce his coverage to 50% of the amount in force immediately prior to August 1, 1964 but in no event shall his coverage fall below that provided under Paragraph 1(g), Section A of Part V of said Agreement.

2. Credit Union

We will continue to extend the benefits provided under the aforesaid Agreement to employees who are on leave of absence as officers of the Credit Union at local plants.

3. Supplemental Workers' Compensation

We will extend the benefits of Section D, Part V of the aforesaid Agreement to employees absent from work due to accident or sickness in cases where we accept his condition as one of occupational origin even though the employee is not receiving Workers' Compensation benefits.

4. International Union Staff Members

Employees who accept employment on the staff of the International Office of the United Steelworkers of America, AFL-CIO-CLC, will for a period of 90 days after such acceptance continue to be covered by the provisions of Sections A, B, C, E and F of Part V of the aforesaid Agreement and notwithstanding the provisions of Paragraph 3 of Article IX of Exhibit A, will be granted accumulation of service for pension purposes for the time of such employment not to exceed the Employee's actual employment with the Employer.

Also, notwithstanding the provisions of Paragraph 3 of Article IX of Exhibit A, Employees accepting permanent employment with the International Union on or after May 9, 1997 will be granted accumulation of continuous service for pension purposes for the time of such employment up to a maximum of 30 additional months, including the 12 month time period set forth in Paragraph 3 of Article IX of Exhibit A unless otherwise notified by the International Union.

Moreover, an employee will be eligible to purchase optional contributory Life Insurance coverage under Section A, Paragraph 2 of the Agreement for the period of time not to exceed the Employee's actual employment with the Employer.

5. Supplementation of Hospital Board and Room

In the application of the first sentence of Paragraphs 17(a) and (b) of Exhibit B-1 of the aforesaid Agreement, the number of days of hospitalization provided under the Program may be added to those provided by the other employer-furnished program referred to therein, but any daily charge for benefits against the Program will be considered as a day of hospitalization.

6. U. S. Veterans' Hospitals

For purposes of determining eligibility for professional ambulance service, Convalescent Nursing Unit and Visiting Nurse Service benefits under Exhibit B-1, U.S. Veterans' Hospitals will be

considered as hospitals under Paragraph 20(e) of Exhibit B-1.

7. Reinstatement of Insurance Coverage on Reemployment

For purposes of determining eligibility for coverage under Part V Insurance, an Employee who is recalled with credit for prior service will be covered immediately upon reinstatement to the payroll.

8. Optional Contributory Life Insurance

For purposes of determining beneficiary or beneficiaries under this program, the provisions of Paragraph 1(d) of Section A, Part V of this Agreement will apply.

Sincerely yours,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated July 14, 1964
from F J Carter to Goodyear Section
of International Policy Committee
covered Paragraphs 1-5)

Paragraph 4 amended July 16, 1979
from O M Sherman to E James Peake, Jr.

Paragraph 6 added April 26, 1973 from
O M Sherman to Kenneth Oldham.

Paragraph 7 added August 25, 1976
from O M Sherman to Kenneth Oldham

Paragraph 8 added July 16, 1979 from
O M Sherman to E James Peake, Jr.

Paragraph 4 amended May 9, 1997
from J M Warren to Richard H Davis

LETTER #4

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

In connection with the Pension, Insurance and Service Award Agreement, dated May 9, 1997, the provision in Exhibit B-1, Paragraph 12, which provides that Survivor Benefits coverage terminates when surviving spouse remarries, shall not apply when such surviving spouse marries either another Shell Retired Employee who has coverage under Exhibit B-1, Paragraph 11 or another Shell Surviving Spouse who has coverage under Exhibit B-1, Paragraph 12.

Sincerely yours,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated August 25, 1976
from O M Sherman to Kenneth Oldham)

LETTER #5

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

Reference is made to medical benefits program identified in Section B of Part V of the Pension, Insurance and Service Award Agreement of May 9, 1997.

The Company may enter into agreements after consultation with the Local Union, in connection with professional services review organizations, hospital pre-admission certification programs, medical foundations, second surgical opinion programs, and other similar programs established by professional organizations of medical care providers in their community

for the purpose of obtaining independent medical opinions with respect to any services, treatments or supplies furnished by providers of medical services covered under the medical benefits programs.

In consideration of the liberalizations and improvements in the Company's medical programs agreed to in the course of these negotiations, the Union agrees to support the determinations of such professional community programs and will recommend to Employees and their dependents the acceptances of such determinations.

Sincerely yours,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

LETTER #13

May 9, 1997

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

During the course of 1997 Negotiations, the Union and the Company conducted in-depth discussions concerning escalating health care costs and the manner in which health care costs continue to exceed the general inflation rate affecting other goods and services.

The parties recognized that continued health care inflation not only has a negative impact on overall employment costs, but also seriously impedes both parties ability to provide health care coverage at present and future benefit levels.

The parties reaffirmed their commitment to provide employees, retirees and covered dependents with a broad range of health care benefits. The parties also renewed their commitment to provide a wide choice of medical service providers to these same individuals, while protecting them from the financial hardship that can result from occurrences of injury or disease.

As a result of the discussions, both parties affirmed their commitment to attempt to minimize the rate of increase in health care costs and to ensure maximum value for funds spent to provide health care.

Both parties determined that an effort should be made to contain health care cost escalation through a joint exploration of the three broad areas:

1. over-utilization of certain medical benefits which are medically unnecessary;

2. under-utilization of cost-effective means to obtain needed medical services, e.g., encourage that medical treatment be rendered in a doctor's office rather than in a hospital emergency room;

3. obtain preferred rates for medical services from major health care providers.

In order to control health care cost escalation, the Union and the Company agree to encourage the Employer and the Local Union to embark on joint efforts at each local plant. Each Local Union will be provided with information pertaining to medical benefits costs and utilization, especially when the local plant's medical benefits costs and utilization appear to exceed the general overall experience of the Company's health care programs.

When the Employer and the Local Union have identified charge levels or billing practices which appear to exceed customary and usual levels, the Employer and the Local Union agree to arrange a joint conference with the provider or providers involved in an effort to resolve the apparent problem. Assistance may be solicited from local peer review organizations, industry associations and other concerned third parties. Special administrative procedures for reimbursement

of charges may be developed when such action supports a constructive solution.

In addition, the Employer and each Local Union shall develop programs and other procedures to address cost containment or benefits utilization at the Local plant level. These programs and procedures shall include, but not be limited to, the following:

1. Conducting discussions with health care providers whose charges exceed those of other providers for similar medical services rendered within the local plant area.

2. Establishing programs to educate employees and retirees about alternate less costly sources of health care that may be available in the local plant community.

3. Encouraging active and retired employee involvement in community health issues which may have an impact on the overall health care program.

4. Initiating steps to improve the administration of health care benefits.

5. The parties agreed to work together in educating employees, retirees and covered dependents on appropriate utilization and cost-effective health care delivery offered by the health care community.

6. Explore any other initiatives which would accomplish the cost-containment objectives both parties recognize as essential.

Sincerely,

/s/ J M Warren
Director
Global Labor Relations

J M Warren

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated April 30, 1982
from F R Tully to Stanley Somo)

* * *

LETTER H

(Not to be printed in booklet)

January 1, 2001

Mr Richard H Davis
International Vice President of Administration
United Steelworkers of America
Five Gateway Center
Pittsburgh, PA 15222

Dear Mr Davis:

The Company shall provide health care benefits under the Comprehensive Medical Benefits Program, Exhibit B-1, the Dental Benefits for Employees and Dependents, Part V, Section E of the Pension, Insurance and Service Aware Agreement dated October 25, 2000 to the extent that such benefits shall be subject to the following limitations:

1. The average annual Company contributions to be paid for all health care benefits per retired employee (including their surviving spouse) who retires on or after May 1, 2000, shall not exceed $11,700 for retirees (including surviving spouses) under age 65.* The age of any such retiree or surviving spouse will be determined as of each January 1 for the entire year.

   The average annual Company contributions to be paid for all health care benefits per retired employee (including their surviving spouse) who retires on or after January 1, 2001, shall not exceed $4,800 for retirees (including surviving spouses) over age 64. The age of any such retiree

or surviving spouse will be determined as of each January 1 for the entire year.

2. If the average annual cost of health care benefits for each such group described in paragraph 1 above exceeds the specified amount, the cost in excess of that amount shall be allocated evenly to all retired employees (including surviving spouse) in such group.

3. Notwithstanding the foregoing, no retired employee or surviving spouse shall be obligated to contribute for such excess health care cost until January 1, 2004.

4. The average annual cost of health care benefits for each group shall be determined by taking the total annual health care payments made by the Company for each group separately and dividing each amount by the number of retired employees (including surviving spouses) in such group as of January 1 of each year.

5. The parties agree that* the amount of the maximum average annual Company contribution for health care benefits as described in Paragraph 1 above shall* be considered a mandatory subject of collective bargaining in any subsequent negotiations. It is further agreed by the parties that this issue shall not be influenced by or bound to any previous or future Board or Court decisions.

Sincerely yours,

/s/ J L Allen
J L Allen
Director Global Labor Relations

Agreed: /s/ Richard H Davis
Richard H Davis

(Original letter dated May 15, 1991
from F R Tully to Thurston Smith)

LETTER OF UNDERSTANDING 2003-6— Retiree Health Care Benefits

November 23, 2003

Karen Shipley
Staff Representative
United Steelworkers, AFL-CIO-CLC
District 8
642 Brady Street
Barboursville, West Virginia 25504

Re: Retiree Healthcare Benefits

Dear Karen:

During 2003 negotiations between M&G Polymers, U.S.A. LLC (the "Company") and the United Steelworkers and its Local 644L (collectively the "Union"), the Company and the Union discussed the costs and burdens associated with various benefits, including medical benefits for active employees and retirees. The parties recognize there are many challenges associated with maintenance of these benefits, which include unique issues resulting from the large number of retirees in comparison to the employees actively working for the Company. At the same time, the Union emphasized the importance of these benefits for active employees, future retirees, and preexisting retirees. The parties during negotiations agreed to certain modifications of the health care benefits available to active employees and retirees, including modifications in plan design and provisions regarding premium cost sharing for these benefits.

The Company and the Union have mutually agreed, during the 2003 negotiations, to make the same health care benefits as will be provided to active employees available to retirees. Except as set forth below, these benefits will be made available to retirees on the same terms and conditions as for active employees, except that premium cost sharing charged to retirees will be based on the amount by which total cost for all retiree insurances (medical, life, etc.) exceed the caps set forth in Letter H dated January 1, 2001. In addition, retirees will not be required to make any contribution toward the cost of health care benefit premiums until January 1, 2006. With the exception of employees currently covered under the Medical Necessity plan, these negotiated benefits will replace any plan or program of health care benefits currently made available to retirees. The parties shall meet commencing by September 30, 2005, or sixty (60) days after the effective date of the collective bargaining agreement succeeding the parties' 2000-2003 Agreement, whichever is later, for the purpose of ascertaining the total costs of all retiree insurances for purposes of setting the retiree premium contribution rates to become effective January, 1, 2006.

In addition [to] the foregoing agreements, the Company and the Union have mutually agreed, during the 2003 negotiations, to defer the discussion of further reasonable cost-reduction measures concerning benefits for the Company's preexisting retirees ("Retiree Benefits") in order to permit these issues to be addressed in a meaningful way, separate and apart

from the other matters that have been the topic of negotiation between the parties. In particular, the Company and the Union have agreed to discuss whether to continue the Medical Necessity plan, which is currently provided only to a limited group of retirees. The agreement to defer this discussion is subject to the following terms and conditions:

- The Company and the Union will meet with one another to discuss Retiree Benefits under the Medical Necessity plan, commencing by September 30, 2005 or 60 days after the effective date of the collective bargaining agreement succeeding the parties' 2000-2003 agreement ("New Agreement"), whichever is later, and continuing at reasonable times thereafter until the retiree Benefits discussions have reached impasse or agreement;

- The parties agree to discuss in good faith whatever further cost-reduction proposals either party may propose. Such discussions will hopefully accommodate the dual objectives, to the extent reasonably possible, of (i) reducing costs and burdens associated with Retiree Benefits and (ii) recognizing the importance of these benefits, throughout the term of the New Agreement, to the Company's preexisting retirees.

- Any agreements reached as a result of the discussions of Retirees Benefits as set forth above may also be applied to the Company's future retirees, but the discussions may not otherwise result in any modification or amendment of the New Agreement without the express and explicit written agreement of the parties.

- The parties also agree that the Retiree Benefits discussions to occur during the term of the New Agreement, as described above, shall in no event be regarded as a reopener of the New Agreement, nor shall any party during the New Agreement's term be permitted to institute or engage in any type of strike, work stoppage, work interruption, lockout or other type of boycott, protest or industrial action of any kind in violation of the New Agreement's provisions, including but not limited to the no-strike/no-lockout provisions contained in the New Agreement.

The Company and the Union also reaffirm their agreement, as reflected in Letters C and H, dated January 1, 2001, that health care benefit plan design and premium cost sharing for retirees shall be considered a mandatory subject of bargaining between the parties, notwithstanding any previous or future court or Board decisions [to] the contrary.

The parties enter into this letter agreement on behalf of their respective organizations and their members as of the 9th day of August 2005.

Sincerely,

/s/ K. A. Korber
Kimm A. Korber
Human Resources Director

ACCEPTED AND AGREED TO
as of the date set forth above:

/s/ Karen Shipley
Karen Shipley
Staff Representative
United Steelworkers, District 8

From: Toselli Marco—MI

Sent: Monday, May 31, 2004 6:36 AM

To: Korber, Kimm KA APG <Kimm.A.Korber@gruppomgus.com>; Pivetta Giorgio—MI <giogio.pivetta@gruppomg.com>

Cc: Crooks, Robert RD APG <Robert.D.Crooks@gruppomgus.com>

Subject: R: Retiree Medical

Kimm's analysis is correct for what concerns the annual cost. It does not consider that cumulative effect on liabilities. From an actuarial point of view a small change would bring a large benefit. Accounting reflects more or less actuarial numbers hence the benefits.

There are two main variables for OPEB that should be kept under control:

- Total actuarial liability
- Annual cost

Total accounting liability: in M&G Polymers balance sheet it is estimated and reported at 26 million, the actual one (reasons are not fully clear to me) is over 47 million. This can be affected by three events:

- Ordinary redesign of the plan. The total liability is the sum of all the services provided by M&G to the retirees. If these services are reduced in number or in financial burden they have a snow ball effect on liabilities. If these reduce the effect flows directly as one shot into income statement, as a positive effect.

In February 2003 it was decided to hire a consultant to analyse these items and their burden. This could be a good basis for evaluating any plan redesign and the reduction of liabilities. It is not clear to me from Kimm's e.mail whether a redesign has been included in the last offer;

- Extraordinary redesign of the plan. Total liabilities decrease also if the number of participants to the plan reduces. This decrease is for ever, since the person would have left the program. The new regulation of Medicare allows for this possibility, since people can find plans outside the companies. Before this was not even an option. In order to take advantage of this situation, M&G's plan has to "be less" than Medicare. If this is not the case and we would need to change the plan. Of course this is a tough negotiation, but returns can be very high. A couple of "unaudited" calculations: 26 million liabilities for 579 people participating in the hourly plan means in average 44,900 $/person. If the plan is modified and 20% of people leave (remember that the vast majority of these people are not from the polyester plant and do not live in WV) it means a 5+ million savings in liabilities and a one shot gain in the income statement. Again to check how far we are from being in such a situation the analysis made by the consultant in Feb '03 would be useful. We may be even in the lucky situation that we are already "less" than Medicare. This would avoid renegotiations. Actuarials should study our plan and let us know where we stand;

- Contribution from government: if the plan is better than Medicare the Government grants a 28% contribution. This is equivalent to 5% of total liabilities,

i.e. a one shot positive contribution of approximately 1.3 million. In any case we will be able to post this, once actuarials will have told us that our plan is Medicare equivalent.

Annual cost: this is the translation on an annual basis of the cumulated liability (not quite right but logically acceptable). Given that annual cost is much lower than total liabilities, the effect is on a single year lower, but it is for ever. I do not know what the annual cash out is today (2 million seems low, Agnesi at one point had indicated 6 million, I cannot remember the final conclusion) but it should be a number not too different (probably a little bit higher) from what Kimm was indicating (let's say 200,000 US$).

Conclusion: the large effect would come from the permanent reduction of liability. This is not only an accounting effect, but it also means that for ever M&G will have less workload (we pay 600,000 US$ per year to handle all the receipts) even the services provided or the number of people participating in the program reduce.

Actions: I would suggest to:

1. review the outcome of Feb '03 results
2. ask an actuarial to review our plan and tell us where it stands vis-à-vis Medicare
3. after these data are analysed determine what to do

Timing: the first two actions I would say immediately so that we can book at least the 28% contribution; the third depends on HR's priorities and negotiations

Sorry for the long e.mail, I wanted to keep it short and did not manage. If needed we can also meet/ videoconference.

Regards

Marco

-----Messaggio originale-----
Da: Korber, Kimm KA APG
Inviato: venerdì 21 maggio 2004 8.14
A: Pivetta Giorgio—MI; Toselli Marco—MI
Cc: 'mccormick.p@mellon.com'; Crooks, Robert RD APG
Oggetto: Retiree Medical

Giorgio/Marco:

Attached is "draft" memo from Pete McCormick summarizing the May 6 Mellon meeting at Apple Grove. Given my travel and other commitments, I did not have an opportunity to follow-up with Pete on this draft document, but appreciating the interest in this subject, I thought it best to forward the memo in its present state, and also share some further information that I believe is both appropriate and relevant to this topic.

<< File: 1635819.doc>>

It is my view that with respect to Medicare eligible salaried employees, we have the ability to change plan designs based on the representations

we have made to existing employees as well as new employees we hire. It is important to recognize that we have no one who is a Medicare eligible salaried retiree at the present time and absent additional retirements, we will have only one in 2005. Additionally, appreciating the relatively small size of the U.S. salaried workforce and the importance for us to remain attractive to existing and potential employees, we need to consider what the implications are of reducing our salaried retiree benefits. If our benefits plans become unattractive or at least less attractive those of other employers we compete against for good candidates, we raise the specter of having our better employees lured away by more lucrative benefits. I don't want to belabor the point here, but with approximately 100 U.S. salaried employees, a large number of whom are in positions in which they could not be easily replaced in the U.S. market, we need to be certain the balance between risk and reward is acceptable when contemplating benefit changes for our salaried workforce.

With respect to hourly employees represented by the USWA, as a part of our negotiations preparations and during the collective bargaining talks, we engaged our employment and labor counsel Seyfarth & Shaw—who by the way represents Goodyear, John Deere, Dow Chemical, and other U.S. based employers with large Union represented workforces—to review our legal risk

around our ability to unilaterally change hourly retiree benefit medical plans. The conclusion was that Goodyear, Shell Chemical, and M&G Polymers did not have a clear and unambiguous right to change such retiree plan designs and to do so would very likely create expensive, protracted and tedious litigation. Moreover, during our bargaining with the Union, they produced one letter that represents a clear agreement between the Company and Union that retiree medical benefits are a mandatory subject of bargaining. Unfortunately, such issues were not identified in the due diligence process prior to M&G's acquisition of Shell's assets, which would have been the time to change the "deal" with the Steelworkers. Furthermore, and as I understand it from Bob Crooks, it was discussed at the Mellon meeting that our last, best, and final offer does not include specific changes in retiree medical related to Medicare prescription drug benefits. This is true and we also put certain design features, e.g., separate deductible for prescription drug benefits, etc., into our last, best and final offer that do move us in the right direction.

Having said this, as we approach 2006, and subject to any agreement which may exist at the time, we are certainly able to ask the Union to bargain our retiree plan design changes and as a matter of law, they are obligated to meet and discuss this mandatory subject with us, but they are not obligated to agree with any proposal we may

make. It is always possible that with sufficient incentive, the Union may agree to changes in retiree medical plan designs. In a discussion I had with Pete McCormick, there are examples of companies in the U.S., such as U.S. Steel, who have been able to successfully negotiate retiree medical plan designs that represent "equivalent" benefits to Medicare, but have not been successful in securing changes to make the Medicare benefits more attractive than the employer's plans. Undoubtedly, there are (or will be) examples of employers who have done the latter successfully, and while any savings are a worthwhile objective in the area of Medicare eligible retiree costs, our ability to capitalize on any plan design changes need to be reviewed both actuarially (to confirm what savings we could count on) and legally (to develop what our options truly are) before we should begin planning on anticipated savings. Again, based on my brief discussion with Pete McCormick after May 6 and subject to a more thorough analysis by Mellon of current and projected demographics in our hourly workforce, with a 5-6% potential savings on an overall medical claims volume for hourly retirees I would estimate at approximately $2MM, our potential savings until our Medicare eligible retiree population would increase, is perhaps $120,000-$200,000 (USD) per year. I cannot comment on how this would tie into accounting standards and other financial reporting measures, but I think it is fair to say M&G Polymers should not count on

millions of dollars of saving in the short-term. Again, I'd be happy to learn that I'm incorrect about this, but based on what I understand at this point, I don't think we'd see the volume of savings reported by some companies in the past months. Their volume of Medicare eligible participant claims for prescription drugs are likely to be orders of magnitude different from what we currently have. To summarize, such savings are clearly of interest to M&G Polymers and we should engage the necessary resources to develop a coordinate and more thorough understanding of what our options are as we move toward 2006, particularly with respect to the hourly retiree medical plans.

AGREEMENT

Between

M&G Polymers USA, LLC
Apple Grove Plant

And

United Steelworkers – USW,
AFL-CIO-CLC

On behalf of

United Steelworkers Local Union No. 644L

August 9, 2005 through November 5, 2008

* * *

ARTICLE XVII
EFFECTIVE DATE AND TERMINATION

This Agreement shall become effective August 9, 2005 and shall continue in effect until 12:01 a.m. November 6, 2008. Thereafter, it shall renew itself for yearly periods unless written notice is given by either party to the other not less than sixty (60) days but not more than seventy-five (75) days prior to the expiration date or any extension thereof that it desires to terminate or amend the Agreement. In the event such notice is given, the parties shall begin negotiations within forty-five (45) days prior to 12:01 a.m. November 6, 2008. At the opening of such negotiations, both parties shall present to each other in writing their proposed changes in said Agreement. If negotiations are not completed prior to the expiration date, this Agreement shall terminate unless extended by mutual agreement of the parties.

* * *

Frey Valerie J

From: Lee Duane P

Sent: Tuesday, December 20, 2005 3:51 PM

To: 'Kimm.A.Korber@gruppomgus.com'

Cc: Robert Crooks (E-mail)

Subject: RE: OPEB Savings Confirmation

Kimm,

Please see my comments below for (3) and (4). I will follow up next year with (1) and (2).

Thanks
Duane

-----Original Message-----
From: Kimm.A.Korber@gruppomgus.com [mailto:Kimm.A.Korber@gruppomgus.com]
Sent: Friday, December 16, 2005 12:36 PM
To: Lee Duane P
Cc: David.Jarrett@buckconsultants.com
Subject: OPEB Savings Confirmation

Duane:

I understand you are out of the office today and I do hope you get to feeling better. I did want to contact you about the possibility of confirming certain numbers that we discussed in Chicago last month related to potential OPEB related savings opportunities. Marco Zanussi will be making a presentation to the Executive Committee in Milan on Wednesday, December 21, and has asked that we work to confirm certain numbers (or at least validate the range of savings) as discussed in Chicago. In order to get Marco

information on time for him to incorporate it into his presentation, I would need the following by no later than noon on Tuesday, December 20:

1. Was (or should) the OPEB liabilities stated for 2001, 2002, 2003, etc., have been adjusted vis-a-vis the layoff of hourly and salary personnel in 2001, 2002, and 2003? What would the impact (or should have been the impact) on the P&L in each of these years due to these layoffs?

2. Was the 2004 OPEB liability adjusted for the hourly layoffs that occurred in 2004? If so, what was the specific financial impact on the P&L attributable to these layoffs?

3. Assuming the 2001 Letter H caps remain unchanged, is the $1.3MM the correct liability number to use for purposes of the balance sheet? [Lee Duane P] The reduction in liability due to application of Letter H to post 2001 bargaining retirees was about $12 million. This is amortized over 9 years which is about $1.3 million. However, the impact on expense is equal to about $2.0 million. This includes the $1.3 amortization plus a reduction in interest cost of about 0.7 million.

4. Assuming the 2001 Letter H caps remain unchanged, but were extended to all bargaining unit retirees, can we confirm that an additional $3MM would be

> taken off the balance sheet and that this would also provide $600M in savings on the P&L for 2005? [Lee Duane P] If we extended Letter H to post 1996 union retirees, there would be an additional reduction in liability of $10 million and a corresponding reduction in expense of $1.6 million. If we further applied the cap to all union retirees, there would be an additional reduction in liability of $2.0 million and a $300,000 reduction in expense. Hence, if we applied the cap to all retirees, the savings on the P&L would be $1.9 million instead of the previous estimate of $600,000.

In my view Duane, questions 1 & 2 can be addressed after December 21, but questions 3 & 4 are especially critical now. If we cannot do an analysis by December 20 that we can have confidence in, when do you believe we could have affirmation of the expected balance sheet and P&L impacts?

I can [be] available to discuss this over the weekend * * * just call me on my mobile phone at (304) 634-7732.

Kindest regards,

Kimm

Kimm A. Korber | Human Resources | M&G Polymers USA. LLC | Office: 304 576 4695 | Mobile: 304 634 7732 | Fax: 815 927 0388 |

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

TACKETT, et al.,	)	Case No. 2:07-cv-00126
Plaintiffs,	)	Judge Gregory L. Frost
v.	)	Magistrate Judge
M&G POLYMERS USA, LLC, et al.,	)	Norah McKann King
Defendants.	)	

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ORAL DEPOSITION OF
WILLIAM DALE WUNDER
AUGUST 9, 2010
Volume 1

****

ORAL DEPOSITION of WILLIAM DALE WUNDER, produced as a witness at the instance of the Plaintiff, United Steelworkers International, and duly sworn, was taken in the above-styled and numbered cause on the 9th of August, 2010, from 8:30 a.m. to 11:41 a.m., before Shanon M. Hair, CSR in and for the State of Texas, reported by machine shorthand, at the offices of Morgan, Lewis & Bockius LLP, 1000 Louisiana Street, Suite 4000, Houston, Texas 77002-5006, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

* * *

[21] Q. [BY MS. KLASS] Was it your understanding that this 1994 Goodyear P&I agreement, as it was originally negotiated by Goodyear, was negotiated with the union to cover the plants and facilities listed on this cover sheet, as it was originally negotiated?

[22] A. [BY MR. WUNDER] I wasn't involved in Goodyear's negotiations, but I can only assume that they were—plants here were covered by Goodyear in their negotiations.

Q. When you were working with this document in 1994 with respect to the Apple Grove plant, did you have an understanding as to what this thing was, the 1994 Goodyear P&I agreement?

A. Yes, I did.

Q. And what was your understanding of what it was?

A. This was the agreement that Goodyear reached with these locations in their negotiations.

Q. None of which were the Apple Grove locations.

A. Correct.

Q. All right. So, you were aware of this Goodyear document. And then is it your recollection that Shell and tne union in 1994 at Apple Grove agreed to adopt this Goodyear agreement?

A. Yes, we agreed to adopt it.

Q. For Apple Grove?

A. For Applegrove.

Q. Effective 1994 to '97?

A. Correct.

* * *

[25] Q. Now, referring back to your declaration, in Paragraph 7, you refer to a July 20, 1994, Letter G, which you indicate is attached as Exhibit D to your declaration. And Exhibit D to [26] your declaration, at the top, the way it was filed with the court ended up being labeled Document 38-2, Page 1 of 10 and Page 2 of 10. Do you see that?

A. Yes, I do.

Q. Is this what you were referring to in Paragraph 7 of your declaration, these—

A. Yes, it is.

Q. —these Pages 1 and 2 of 10? Your declaration states that Shell and the union specifically discussed this letter during 1994 bargaining and mutually agreed that this letter was part of the 1994 Goodyear P&I agreement.

Who was in attendance when that was discussed?

A. As best I recall, they were the same individuals that were involved in the rest of the negotiations, so—

Q. And who was that with respect to Letter G?

A. The folks that signed the agreement; so, myself, Bob Roberts, Mike Harrington, and the three union folks who I mentioned previously.

Q. And those were Floyd Sayre and Mr. Rollins and Mr. Knopp?

A. Yes, that's right.

Q. Was anyone else there during these discussions in 1994 that you're describing in Paragraph 7 of your declaration?

A. There may have been a united or rubber workers representative whose name I can't recall.

* * *

[30] Q. [BY MS. KLASS] Now, is it your testimony that Exhibit D to your declaration, which is this Letter G that we were looking at a moment ago, the Goodyear Letter G—is it your testimony that Letter G itself was physically on the table in front of you when you were negotiating with Apple Grove in 1994?

A. Yes that's my recollection.

* * *

[43] Q. Now, taking these in sequence, starting with 138, which appears to be Mr. Kruse's letter to Mr. Roberts confirming that Goodyear is going to send 600 copies of the 1994 P&I agreement to Shell, do you know why Mr. Kruse wrote this letter to Mr. Roberts or why he was sending these booklets?

A. Yes, I do. He was sending the booklets as a courtesy to Bob because we had agreed with the union to adopt the P&I agreement that Goodyear and the URW had agreed to and at that point we did not have the 5-by-8 booklets to distribute and so we—Bob had asked Mr. Kruse if he could provide copies that the union folks could share with their members so they would see what the details of the P&I agreement were.

* * *

[44] Q. Now, the Letter G that we talked about a moment ago, the Goodyear 1994 Letter G, that was not printed in the booklets that was distributed to the union members, correct?

A. Correct.

[45] Q. Why not?

A. That was a practice that Goodyear had adopted that they did not include all of the letters in the document, that they were still in effect.

* * *

[49] Q. [BY MS. KLASS] So, in 1997, is it correct that your negotiations pertaining to the Apple Grove plant resulted in this P&I agreement that you signed on Pages 221 and 222?

MS. DAVIDSON: I'll object to the form.

MS. KLASS: What's wrong with the form?

MS. DAVIDSON: Same point that I made earlier, to the extent that it implies that this is the only format in which the agreement appeared.

Q. [BY MS. KLASS] Am I right?

A. Yes, that's my signature.

Q. So, this stands in contrast to 1994 where you did not end up signing a P&I agreement as such, correct?

A. Right. I did not sign the Goodyear P&I agreement in 1994. We agreed to adopt it.

Q. So, in '94, there was no P&I agreement that you could pick up at Shell that had your signature on it in terms of an agreement itself versus a letter. I'm distinguishing the letters now. I understand you signed some letters, but if we set aside all the letters that you signed, there was no P&I agreement or booklet in '94 that you signed for Apple Grove, [50] correct?

A. Not that I recall. We just had the Goodyear document.

Q. But you didn't sign it, did you?

A. No.

Q. But in '97, the parties do create a document and you sign it on Pages 221 and 222, correct?

A. Yes.

* * *

[53] Q. And that is Letter H dated May 9, 1997, right?

A. Correct.

Q. Now, was it your understanding that this letter, as originally prepared, was yet another Goodyear letter?

A. Yes. It was another Goodyear letter applicable to the P&I agreement.

Q. In your declaration, you say in Paragraph 9 that Shell and the union specifically discussed this letter during '97 bargaining and mutually agreed that it was part of the '97 Goodyear P&I agreement.

Did you discuss Letter H during the 1997 bargaining?

A. Yes, we did.

Q. When I say "you," I mean literally you, Dale Wunder.

Did you yourself?

A. Yes.

Q. And who else?

A. Believe it would have been Paul McIntyre, Mike Harrington, and perhaps David Worley, best I recall.

Q. Where does Mr. Worley work today?

A. He still works for Shell, and I believe he works at [54] the Port Arthur refinery.

Q. What state is that in?

A. Texas.

Q. And who else was present during these 1997 discussions pertaining to Letter H?

A. Beyond Mr. McIntyre and Harrington?

Q. Yes.

A. It would have been Floyd Sayre, Howard Knopp, Don Rollins, and potentially the steelworker representative as well.

Q. And who was that?

A. I believe his name was Joe Chapman, but I don't recall if he was in the room for exact discussions on every item. I'm sure he was not.

Q. What did you say about Letter H?

A. I said that as with prior negotiation, this letter applied to the P&I agreement.

* * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

- - - -

TACKETT, et al.,	)	
	)	
Plaintiffs,	)	Case No. 2
	)	:07-cv-001
-vs-	)	26
	)	
M&G POLYMERS USA, LLC, et al.,	)	
	)	
Defendants.	)	

- - - -

DEPOSITION OF: DAVID E. DICK

- - - -

DATE: August 19, 2010
Thursday, 9:50 a.m.

LOCATION: United Steelworkers
Legal Department
Five Gateway Center
Pittsburgh, PA 15222

TAKEN BY: Plaintiff United
Steelworkers International

REPORTED BY: Beth E. Welsh
Notary Public
QCR Reference No. BW2133

* * *

[BY MS. KLASS]

[4] Q. Could you give us your full name, please?

A. David Ernest Dick.

[10] Q. When did you find out that you were going to be assisting M&G with its collective bargaining in the fall of 2000?

A. Specifically I can't tell you, but obviously it was before the September date when I sat at the [11] table.

Q. Do you recall who contacted you?

A. Not precisely, but likely the plant manager.

Q. Was that Mr. Bowen?

A. Yes, ma'am.

Q. Robert Bowen?

A. Yes, ma'am.

Q. Also sometimes known as Bob Bowen?

A. I think that's a fair statement.

Q. I think the bargaining notes reflect that sometimes.

A. Okay.

Q. So he was the plant manager of the Apple Grove facility in West Virginia that M&G had purchased from Shell; correct?

A. That's my understanding.

* * *

[78] Q. Once you arrived were you the chief negotiator for the company from your point of view?

A. As that phrase is generally used, I think so.

Q. Did you continue to talk with Mr. Bowen and Mr. Rosh and Ms. Cook as you were doing what was necessary to fulfill your role as chief negotiator during the bargaining?

A. They were present with me during the bargaining, yes.

Q. And would you use them as resources for information?

A. Yes.

* * *

[98] Q. Did you prepare this memo of October 17—well, let me ask you differently, how did you go about preparing this memo of October 17, what was your methodology or process in preparing it?

A. In what sense?

Q. Well, how did you go about doing it? Did you have some notes about what the union's inquiry had been that you used and then prepared a document that was responsive to your notes or did you go by your recollection, did you go by talking to other people? That's what I'm asking, what was your process?

[99] A. Again, Renate, I can't tell you with precision here, but some or all of those things. I mean, I just sat through and had been sitting through negotiations over these very issues.

Q. And so, therefore, what?

A. It was responding to those issues.

Q. That had been raised at the table?

A. Yes.

Q. By the union?

A. Yes.

Q. So the first paragraph of your memo says provided that the company can obtain necessary changes allowing it the flexibility it seeks, the company is willing to make improvements to the pension plan in terms of an increase to the multiplier in each year of the contract; an increase to the supplemental benefit; removal, to the extent possible, of earnings limitations, and a common expiration date for the P&I Agreement and the basic labor agreement, correct, that's what you wrote in the first paragraph?

A. That's what it says.

Q. So to the best of your recollection these were all issues that had been discussed at the table [100] up until that point; correct?

A. I would presume so as I sit here today.

Q. Your best recollection is that you were writing this in response to things that the union had raised at the table; correct?

A. That is correct, and the fact that Randy—I believe it was reflected in things we've already seen

in these notes, to the extent that they're accurate, was uncomfortable that there was something not more concrete about our position on whether we were going to respond to his request for pension improvements, et cetera, hence you see this document.

Q. In the second paragraph you wrote the applicability of Letter H, paren, FASB—this time spelled in caps F-A-S-B, so in paren FASB language, question mark, end paren, to the P&I Agreement and to M&G is less than clear.

So to reread that sentence, it says the applicability of Letter H (FASB letter?)—

MS. DAVIDSON: FASB language.

MS. KLASS: Thank you. I have to start all over again now because I said it wrong.

MS. DAVIDSON: Take 3.

[101] MS. KLASS: Thank you.

BY MS. KLASS:

Q. The applicability of Letter H (FASB language?) to the P&I Agreement and to M&G is less than clear. In fact, the company believes it does not apply to M&G (or Shell previously). Retiree health benefit contributions are set out on Page 115 of our P&I Agreement. Letter H is not in our Agreement.

So that's your second paragraph of your memo; correct?

A. Yes.

Q. And was that written in response to Randy Moore's proposal that the FASB date be extended?

A. You call it a proposal, he said this was not formal, so he was throwing those out. If you go back and reread the notes, he said this is not a formal offer. Notice this does not say it's a counteroffer, it's a response to his statement.

Q. It's a response. So this was a response to his statement—

A. Of the things he was interested in.

* * *

[102] Q. So this paragraph that we just read having to do with Letter H and FASB language, that was written in response to his table comments about extending the FASB date; correct?

A. To the best of my recollection.

Q. Yes?

A. I said to the best of my recollection.

Q. And that means to the best of your recollection, yes; correct?

A. To the best of my recollection it does.

Q. When you wrote that the company believes it does not apply to M&G or Shell previously. Now, that's a pronoun it, the prior sentence referred to Letter H, so when you write in your second sentence,

in fact, the company believes it does not apply to M&G or Shell previously, you were referring to Letter H; correct?

A. That is correct.

Q. Now, what led you to say in your memo that the company believes that Letter H does not apply to M&G or Shell previously?

A. The information I had at that time and the fact that the Letter H document did not exist in the back of that document that I had.

* * *

[118] Q. So at the table you said to them, in effect, union, you have to consider where you want to put the money that we're prepared to offer you; correct?

A. Yes, ma'am.

Q. Whether that's in dental, wages or pension; correct?

A. That would be correct.

* * *

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

HOBERT FREEL TACKETT, et al, Plaintiff vs. M&G POLYMERS USA, LLC, et al, Defendant	)	CASE NO. 2:07-cv-00126

- - -

DEPOSITION OF DUANE P. LEE

Taken at the law office of:
MORGAN LEWIS & BOCKIUS
One Oxford Centre, 32nd Floor
Pittsburgh, PA 15219

Tuesday, September 14, 2010

- - -

Reported by:

QUALITY COURT REPORTING
Leaette Cavaliere, Court Reporter
7012 Kevin Drive
Bethel Park, PA 15102
(412)833-3434

* * *

[7] [BY MR. COOK]

Q. With that, when did you begin doing work for M & G Polymers?

A. If I remember correctly, sometime in 1999.

Q. How did you come to do work for them, to be assigned?

A. I am the FAS 106 actuary for Buck Consultants in the Pittsburgh office. We were contacted to do some due diligence work in the acquisition of certain division from Shell by M & G Polymers and we were asked to do a deposition and I was asked to look at the FAS 106 section of that process.

Q. Okay, now you're an actuary, correct?

A. Correct.

Q. And you're a fellow of the Society of Actuaries?

A. Yes, I am.

Q. You are also an enrolled actuary?

A. Yes, I am.

* * *

[11] Q. Let's mark statement of Financial Accounting Standards No. 106 as deposition Exhibit 234, please. That's a large document that we obtained by license from the Financial Accounting Standards Board. Do you recognize that, sir?

A. Not the specific document, but I'm aware of its contents.

Q. And is that the statement of Financial Accounting Standards that guides the preparation of the calculation and reporting of other postemployment retirement benefit obligations for employers?

A. Yes, it is.

Q. So there are some acronyms that are used in the process of reporting under FAS 106, and I want to make sure that we're on the same page. If I say OPEB, O-P-E-B, do we understand that together to be other postemployment retirement benefit obligations?

[12] A. Yes, it's used synonymously with FAS 106.

MR. ICE: Synonymous with what?

THE WITNESS: With 106. OPEB and 106 are used interchangeably.

BY MR. COOK:

Q. And then APBO, accumulated postretirement benefit obligations?

A. Yes.

Q. So APBO and OPEB are two phrases that we can—we are going to see that in other documents in a few minutes, okay.

Now under the requirements of FAS 106, Mr. Lee, describe the process by which you, the actuary, obtained the data necessary to prepare the calculation and the report. How do you go about doing that?

A. In the normal course of business, when you are doing an annual evaluation, we would contact the client and ask them for the necessary data which includes census information, medical claims information, plan documents and any other related documents that may be relevant to the calculation.

Q. Would that include collective bargaining agreements?

[13] A. Yes, it would.

Q. And if there are provisions of either a plan document or a Collective Bargaining Agreement that talk about eligibility or duration of benefits, how do you deal with that?

A. We build that into our model accordingly.

* * *

Q. You don't hold yourself out to be an expert in collective bargaining agreements, do you?

A. I am an expert at valuing benefits and I have [14] been involved, but I am not an expert in collective bargaining process, no, I'm not.

Q. And you don't have as part of your practice on an ongoing regular basis the review and interpretation of collective bargaining agreements, do you?

A. No.

* * *

[19] Q. All right, so you were contacted by M & G Polymers or Mr. Kenji?

A. Yeah, or a representative.

Q. And asked to value the OPEB for this facility?

A. Well, not necessarily to value it but to take a look at the numbers that Shell was [20] presenting to them as it relates to the liabilities and to see if they were reasonable, and also to do some estimates, "what if" estimates. What if they maybe laid off some people? What if they made other changes?

* * *

[25] Q. Now when you received this, and any follow-up data or material from Miss Bald, what was the duration of the postretirement benefits for hourly employees of the Point Pleasant facility?

A. It was my understanding that the ration of benefits is for the lifetime of the retiree if they were enrolled in the plan.

* * *

[29] Q. And, okay, let me hand you what we will mark as 239. Document 239 is—may I see your copy for a moment, please? This is a multi-page document dated December 17th, 1999, on the letterhead of Buck Consultants and consists of Bates stamp Buck 07513

through Buck 07522. This is a letter addressed to Mr. Marco Ghisolfi, G-h-i-s-o-l-f-i, and it is signed by two persons, David R. Jarrett and Duane Lee, listed as consulting actuary. Did you author or co-author this letter, sir?

A. Yes, I did.

Q. And the attachments were included at your request?

A. Some of them. Some of the attachments relating to the OPEB.

Q. And who is Mr. Jarrett?

A. David Jarrett is a pension actuary that works in our Pittsburgh office that was doing the work for M & G Polymers at the time.

* * *

[30] Q. So he worked on the pension issues in this letter and you worked on the OPEB issues?

A. Correct.

* * *

[31] Q. Now with that in mind, Mr. Lee, on the third page of the document, if you look at the Point Pleasant hourly box, it has the accumulated benefit obligation, projected benefit obligation and market value of assets. Do you see that?

A. Yes, I do.

Q. I take it from reviewing this that you were assessing what the OPEB was or what you estimated it to be utilizing different interest rate assumptions at that time?

A. We were—the table you are referring to refers to the pension liabilities?

Q. I'm sorry, that's right, it does. I should have turned back to the page five which is the same. Okay, now that's the summary of OPEB liabilities, accumulated postretirement benefit obligation for each of the various categories. And you were just valuing it with different interest rate assumptions?

A. We were estimating the liabilities based on different discoveries, yes.

Q. And am I correct, sir, that you valued that based upon a lifetime benefit?

MS. DAVIDSON: Object to the [32] extent that it ca for a legal conclusion.

BY MR. COOK:

Q. I'm not asking for a legal conclusion. I'm asking what assumption you used in preparing the evaluation.

A. If I remember correctly, the benefits, on the line benefits were lifetime benefits.

Q. And there were no retiree contributions, correct?

A. If that is what Shell assumed, that is correct.

Q. If you turn to page nine of the document, the summary of PET Business Exhibit 7, Roman numeral seven, see that at the top?

A. Yeah.

* * *

[33] Q. With the conditions that you set forth earlier in your letter, in the document, am I correct that you estimated the OPEB liability for the hourly employees and retirees of the Point Pleasant facility at 25.6 million dollars as of December 31st, 1999?

A. Based on the paragraph below the table, it appears as if those numbers were calculated by Price Waterhouse Coopers and the numbers in the table were restating the numbers calculated by Price Waterhouse Coopers.

Q. So this is not your calculation.

A. That is correct.

* * *

[36] Q. Well, let's look at the first page then. This is Exhibit 9, the PET business, summary of net pension and OPEB liabilities, and then you have at the bottom of that chart an OPEB, says gross OPEB liability plan assets and net OPEB liability. The net OPEB liability shows a difference in calculation as

calculated by Shell and by Buck Consultants; is that correct?

A. That is correct.

Q. Do you recall today why the difference? Was it an interest rate assumption? Was it some contribution assumption?

A. No, we do not – I do not know the difference. We were not able to reconcile the difference.

* * *

Q. Mr. Lee, deposition Exhibit 241 is a January 3rd, 2000, letter to Marco Ghisolfi.

* * *

[121] Q. Now going down, you walk through a scenario and there is a sentence in here that reads: However, as soon as the cost reaches $4,800, (as defined in Letter H), the retiree is responsible for the entire amount in excess of $4,800.

Is that correct?

A. Correct.

Q. Is that the way you valued the benefits once you recognized Letter H?

A. Yeah, we assume that the company's cost is limited to $4,800 per retiree.

Q. Then you go on to say in the next sentence: Therefore, when he reaches age 80 he would have to

pay an additional $3,500 ($8,300 less Letter H cap of $4,800) in order to maintain coverage.

Correct?

A. Correct.

Q. Now the next to the last paragraph it says: By recognizing Letter H future medical [122] inflation does not have a significant impact on the FAS 106 cost.

Why is that?

A. Because the inflation—as you get higher inflation, it increases the overall costs but the company's obligation is limited to the cap amount so in effect, if you have inflation, it only increases the retiree contribution, not the company's cost.

Q. So the impact or effect of recognizing Letter H is, as you say here, a significant reduction in FAS 106 costs to the company. The FAS 106 expense for 2005 would be approximately four million without Letter H and about 2.7 million with Letter H. Correct?

A. Correct.

* * *

[128] Q. And this is a multi-page document Bates stamped Buck 07672 through 07676. Please mark this as deposition Exhibit 284. This is a two page document dated December 20th, 2005, from you to Kimm Korber, copied to Robert Crooks, and then

the subject is OPEB's savings confirmation. Your message is: Kimm, please see my comments for three and four below. I will follow up next year with one and two.

Where are your comments?

A. Its right after the Lee, Duane P., in parentheses.

Q. Okay, now I'm lost. Oh, I see, you've inserted them inside the number.

A. Correct.

Q. So you don't have anything for one and two, you have three and four.

A. Correct.

Q. All right, so let's look at that. The question asked of you by Kimm Korber on December 16th, 2005, in item number three was: [129] Assuming the 2001 Letter H cap remains unchanged, is the 1.3 MM the correct liability number to use for purposes of the balance sheet?

Did you then insert the following text?

A. Appears so, yes.

Q. The reduction in liability due to application of Letter H to post 2001 bargaining retirees was about 12 million. This is amortized over nine years which is about 1.3 million. However, the impact on expense is equal to about two million. This includes

the 1.3 amortization plus reduction in interest cost of about 0.7 million."

That last part was all yours.

A. Yes.

Q. So you were advising him of what the savings incurred or enjoyed by M & G was as a result of the recognition of Letter H for post 2001 bargaining retirees, correct?

A. Yes, he was apparently mistaking the 1.3 million dollars as a liability number and not as part of the expense number.

Q. Now number four, he asks: Assuming the 2001 Letter H cap remains unchanged, but were [130] extended to all bargaining unit retirees, can we confirm that an additional three million, 3 MM would be taken off the balance sheet and that this would also provide 600 million in savings on the P and L for 2005?

And then you answer: If we extend—I'm sorry—if we extended the Letter H to post 1996 union retirees, there would be an additional reduction in liability of ten million and a corresponding reduction in expense of 1.6 million. If we further applied the cap to all union retirees, there would be an additional reduction in liability of 2.0 million and 300,000 reduction in expense. Hence, if we applied the cap to all retirees, the savings on the P and L would be 1.9 million instead of the previous estimate of 600,000.

Is that correct?

A. Yes.

* * *

[134] Q. Do you recall, Mr. Lee, sitting today, after having reviewed these documents, when and why the decision to apply Letter H backwards to [135] all retirees was made?

A. No, I don't.

Q. Did you assist in making that decision?

A. No, I did not.

Q. Were you consulted with respect to it?

A. No, I was not. Sorry, I was consulted regarding the financial impact but not whether it was applicable or not.

Q. So the decision on applicability was not part of your process.

A. Correct.

* * *

[139] In front of you is a December 16, 1999, letter with the names David Jarrett and Duane Lee on Buck Consultants' letterhead. This is deposition Exhibit 286. Did you author or direct the preparation of this letter?

A. Yes, I did.

Q. And this is to Aly Kanji, Meynor Limited, in London.

A. Yes, that's what it says.

Q. At whose request did you prepare this?

A. I would imagine it's probably Aly Kanji's request.

Q. Was use of the phrase ABC Company a substitute identifier for Shell Chemical?

A. Probably was.

Q. And this document contained the assumptions of lifetime duration and no retiree contribution as well?

A. If I remember correctly, yes, I think that was the basis.

* * *

[175] BY MS. DAVIDSON:

Q. Mr. Lee, you've been asked a number of times today about the discovery, quote-unquote, of Letter H and different versions of Letter H. My question is, do you actually know when M & G first became aware of any version of Letter H?

A. Not specifically, no.

[176] Q. And do you actually know when exactly M & G came into the possession of any version of Letter H?

A. Not specific dates or anything, no.

Q. That's all that I have.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

- - - -

TACKETT, et al., Plaintiffs, -vs- M&G POLYMERS USA, LLC, et al., Defendants.	)	Case No. 2:07-cv-00 126

- - - -

DEPOSITION OF: JAMES F. KRUSE

- - - -

DATE: September 15, 2010
Wednesday, 9:06 a.m.

LOCATION: United Steelworkers
Legal Department
Five Gateway Center
Pittsburgh, PA 15222

TAKEN BY: Plaintiff United
Steelworkers International

REPORTED BY: Beth E. Welsh
Notary Public
QCR Reference No. BW2147

* * *

[4] [BY MS. KLASS]

Q. This is the deposition of James Kruse being taken pursuant to Notice and Request for Production of Documents and Subpoena.

* * *

[7] Q. Could you give us your full name, please?

A. James F. Kruse, K-R-U-S-E.

* * *

[9] Q. Your Declaration indicates that you worked for Goodyear Tire & Rubber Company from June 19, 1967 until December 31, 2001. Are those dates accurate to the best of your recollection?

A. Yes, they are, as an employee.

* * *

[19] [BY MS. KLASS] from 1978 until you retired, I'm paraphrasing here, you participated in Goodyear master bargaining.

* * *

Q. So that meant that you participated in that master Goodyear negotiation process—

A. Yes.

Q. —from 1978 until December 31, 2001; correct?

A. Yes.

* * *

[22] [BY MS. KLASS] Q. So you first started having some responsibility for the Point Pleasant Plant or the Apple Grove Plant in 1982?

A. That is correct.

Q. And that was in connection with your new position as manager of labor relations for engineered and general products plants?

A. Yes.

Q. Which included the Apple Grove facility?

A. Yes.

Q. How many plants did you have in your sphere of responsibility starting in 1982?

A. It varied over time by one or two, but a good number would be that I had human resource responsibility for fifteen plants.

Q. So it would be approximately fifteen starting in 1982 maybe up or down by one or two from there depending on the year?

A. Yes, things get bought and things get sold.

Q. So it might range from thirteen to seventeen approximately?

[23] A. Approximately. Fifteen is a good solid number.

Q. What was your responsibility between 1982 and 1991 for those fifteen plants?

A. The human resources departments in those plants worked for me.

Q. They reported to you?

A. Human resources manager or at that time industrial relations manager reported to me and to their plant manager.

* * *

[44] Q. Now, turning to July 1, 1991 now, you then became Goodyear's director of benefits policy and planning; correct?

A. Yes.

* * *

[45] Q. What were your responsibilities in that role?

A. I had the responsibility for all of Goodyear's employee benefits worldwide, but principally it was U.S. plants and as a subset of that principally—a lot of my time was spent on master negotiations bargaining. I became the chief spokesman for benefits of the Goodyear Tire & Rubber Company.

* * *

[79] Q. So retirees who were under a Goodyear health plan might have to pay deductibles for certain medical procedures pursuant to the plan because it was a plan feature that they'd have to pay deductibles; correct?

A. Correct.

Q. Would they possibly have to pay copays?

A. Yes.

Q. And in your mind what's a copay?

A. A percentage of the allowable charge.

Q. Would that also be a plan feature?

A. Yes.

Q. And they might have to pay a contribution toward the cost of the health care depending on the language in the P&I Agreement at the time of [80] their retirement; is that right?

A. Yes.

Q. Any other financial obligations that retirees might have had for health care other than deductibles, copays and contributions toward the cost of health care?

A. The only other one would be, I think, ineligible expenses.

Q. Ineligible expenses? So if you had a procedure for which there was no coverage—

A. A medical procedure, but it wasn't covered under the plan, then that was the employee or retiree's responsibility.

Q. And you just had to pay your doctor or hospital yourself because it wasn't a covered benefit?

A. Correct.

Q. So I've got deductibles, copays and ineligible expenses all in the category of things a retiree might have to pay for pursuant to plan design or plan features, would that be fair?

A. Yes.

Q. And those expenses would be universal to all Goodyear retirees who retired under a Master P&I Agreement, correct, depending on—

A. No.

[81] Q. I understand the objection to my question, because plan design might change from year to year as well?

A. Yes, deductibles and copay amounts can change.

Q. Absolutely.

A. And past retirees, as we call them, past retirees—they may receive improvements or takeaways based on what happens in a future bargain, but, basically, you retire under the plan you're under as modified going forward. You're under your plan as modified going forward by something called Letter C, which we may get to or may not.

* * *

[111] Q. This training center meeting, was the purpose of that to explain the same concept of trading off wages for improved pension benefits?

A. That was a very small part of the meeting.

Q. Was that also covered there?

A. Briefly.

Q. What else did you discuss at this meeting?

A. We discussed every change that was made to the pension and insurance agreement as a result of the 1991 bargain that impacted people in Point Pleasant.

[112] Q. And what changes did you review?

A. The list of changes that's attached to the agreement.

* * *

Q. And that's my question, what topics did you cover in the Point Pleasant training center meeting?

A. The topics that are outlined in the list of changes to the agreement that is attached to the actual agreement.

Q. You're talking about the master P&I?

A. The master agreement, that list of changes. And when we got to the FASB change, I briefly explained that without putting Mr. Rollins in a difficult position with a surprise topic.

Q. What do you mean by that?

A. Well, I'm not going to stand in front of management and union people and say, oh, and by the way, if you want your pension, you're going to have to pay for it, next topic. You just don't do those things.

You don't embarrass your local union president in public, and they work [113] hard not to do the same to us.

* * *

[114] Q. Let me make sure I ask my question and then well get your answer on the record. My question is do you have any recollection of what you said concerning the FASB issue as you sit here today?

A. I read the statement that's on the list of changes, that's what was said, period.

Q. You recall reading something to them?

A. Yeah, we were very careful about how we dealt with FASB in public, because there were all kinds of other issues surrounding it unrelated to organized labor.

Q. What do you mean you were very careful as to what you said in public?

A. If—everything that was said and done with respect to FASB in every corporation, not just in Goodyear, was subject to approval of our outside auditors, our law department. I mean, this was big money, and it was a big issue, and you did not in public make extemporaneous statements about the impact of FASB. In public you stuck to a script, and the script for Point Pleasant in the big meeting is in the list [115] of changes.

Q. So your best recollection is whatever it said on this document you just read?

A. For that change, yes.

Q. Period?

A. Yep.

* * *

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

EASTERN DIVISION

HOBERT FREEL TACKETT, ET AL.,	.	
PLAINTIFFS,	.	CASE NO. 2:07-CV-126
VS.	.	
M&G POLYMERS USA, LLC, ET AL.,	.	COLUMBUS, OHIO MAY 9, 2011
DEFENDANTS.	.	

. . . . . .

VOLUME I

TRANSCRIPT OF BENCH TRIAL PROCEEDINGS

BEFORE THE HONORABLE GREGORY L. FROST
UNITED STATES DISTRICT JUDGE

APPEARANCES OF COUNSEL:

FOR THE PLAINTIFFS: DAVID M. COOK, ESQUIRE
JENNIE G. ARNOLD, ESQUIRE
LAURA L. FISCHER, ESQUIRE

FOR THE DEFENDANTS: PHILIP MISCIMARRA, ESQUIRE
JOHN RICHARDS, ESQUIRE
DEBORAH S. DAVIDSON, ESQUIRE
CHRISTOPHER A. WEALS, ESQUIRE

- - -

DENISE ERRETT & SHAWNA EVANS,
FEDERAL COURT REPORTERS
(614) 719-3029

* * *

[82] WOODROW PYLES,

AFTER HAVING BEEN FIRST DULY SWORN, TESTIFIED AS FOLLOWS:

- - -

DIRECT EXAMINATION

BY MS. ARNOLD:

Q. Good morning.

A. Good morning, Jennie.

Q. Can you confirm for us this morning that you're a plaintiff in this suit?

A. That's correct.

Q. All right. And why are you here today on behalf of this plaintiff class?

A. I'm representing the class because of the imposition of contributions that's been imposed upon us by M&G Polymers and the removal of some of our benefits as well.

[83] Q. Okay. And you are a retiree of the Point Pleasant Polyester Plant?

A. That's correct.

* * *

[110] Q When we closed before lunch, we had been talking about the 1994 CBA and pension and insurance agreement. Can you remind us, again, of what year you retired?

A January 1st, 1996.

Q So what was the governing document in control of your benefits when you retired?

A 1994 P&I agreement.

Q And this contained the 95 point provisions?

A Yes.

* * *

[114] Did you have any questions about your medical benefits at the time of your retirement?

A I did not have any personally, but there was one question that I was concerned about that the medical necessities program, which ended in April 19, 1997, would, in fact, it continue on for those who elected that program when they retired in '96?

Q Who did you ask that question of?

A I believe it was Mr. Harrington.

Q What response did you get?

A Yes.

Q Yes what?

A Yes, they would continue the medical necessities program for those who elected that program when they retired.

Q For whom was that program ending?

A The active employees.

* * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

HOBERT FREEL TACKETT, ET AL.,	.	
PLAINTIFFS,	.	CASE NO. 2:07-CV-126
VS.	.	
M&G POLYMERS USA, LLC, ET AL.,	.	COLUMBUS, OHIO MAY 13, 2011
DEFENDANTS.	.	

. . . . . .

VOLUME V
TRANSCRIPT OF BENCH TRIAL PROCEEDINGS
BEFORE THE HONORABLE GREGORY L. FROST
UNITED STATES DISTRICT JUDGE

APPEARANCES OF COUNSEL:

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* * *

[46] KIMM KORBER,

AFTER HAVING BEEN FIRST DULY SWORN, TESTIFIED AS FOLLOWS:

DIRECT EXAMINATION

BY MR. WEALS:

Q. Good morning, Mr. Korber.

THE COURT: Yes, Mr. Weals, you may proceed on direct examination.

MR. WEALS: Thank you, Your Honor.

BY MR. WEALS:

Q. Good morning. Mr. Korber, what's your current job?

A. I'm the Human Resources Director for M&G Polymers USA.

Q. How long have you had that job?

A. Since approximately 2003.

Q. And prior to being Human Resources Director, what position did you hold with M&G?

A. I was hired in 2001 to be the HR Manager for the Apple Grove Plant.

Q. When in 2001?

A. January 15th of 2001.

* * *

[212] [BY MR. COOK]

Let's look at Plaintiffs' Exhibit 198, please. This is a March 3rd, 2005, to Mr. Bob Crooks, controller, M&G Polymers, from Duane Lee with a copy to you. Is that correct?

[BY MR. KORBER]

A Yes.

Q Did you receive a copy of this?

A I'm sure if I was copied on it, I received it.

Q The reference is final 2004 expense and December 31, 2004, OPEB disclosure results.

A That is the subject line.

Q The second paragraph shows a change in numbers, the change is decline in the APBO, or Accumulated Postretirement Benefit Obligation, and the OPEB expense, correct?

A That's what it says.

Q Pretty large drops. The APBO dropped from $46,516,142 to 37,334,135, correct?

A It did.

Q And then the expense, the OPEB expense dropped from 3,578,877 to $2,776,655?

A That's what this says.

Q And the next sentence reads: The reduction is *primarily* due to the application of Letter H which resulted in a reduction in APBO of $5.2 million. Correct?

[213] A That's correct.

* * *

PETITIONER'S BRIEF

RECORD AND BRIEFS

No. 13-1010

FILED
JUL 17 2014
OFFICE OF THE CLERK

In The
Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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QUESTION PRESENTED

Whether, when construing collective bargaining agreements in Labor Management Relations Act (LMRA) cases, courts should presume that silence concerning the duration of retiree health-care benefits means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds; or should require a clear statement that health-care benefits are intended to survive the termination of the collective bargaining agreement, as the Third Circuit holds; or should require at least some language in the agreement that can reasonably support an interpretation that health-care benefits should continue indefinitely, as the Second and Seventh Circuits hold.

PARTIES TO THE PROCEEDINGS AND RULE 29.6 STATEMENT

The caption of this petition contains all parties to the proceedings.

Petitioner M&G Polymers USA, LLC, is a wholly owned subsidiary of Mossi & Ghisolfi International and is incorporated in West Virginia. Petitioner M&G Polymers USA, LLC Comprehensive Medical Benefits Program For Employees And Their Dependents is a medical benefits program sponsored by M&G. Petitioner The M&G Catastrophic Medical Plan is a medical benefits program sponsored by M&G. Petitioner The M&G Medical Necessity Benefits Program Of Hospital, Surgical, Medical, And Prescription Drug Benefits For Employees And Their Dependents is a medical benefits program sponsored by M&G. Petitioner The M&G Major Medical Benefits Plan is a medical benefits program sponsored by M&G.

TABLE OF CONTENTS

	Page
Question Presented	i
Parties to the Proceedings and Rule 29.6 Statement	ii
Table of Contents	iii
Table of Authorities	v
Opinions and Orders Below	1
Statement of Jurisdiction	1
Statutory Provisions Involved	1
Statement	2
A. Background	3
B. Facts and Procedural History	6
Summary of Argument	12
Argument	15
I. The Sixth Circuit's *Yard-Man* Presumption Violates Ordinary Rules Of Contract Interpretation, Conflicts With Congressional Intent, And Disserves National Labor Policy	15
A. Health-Care Benefits Granted Without A Durational Clause Or Vesting Guarantee Terminate With The Agreement That Provides Them	16
B. *Yard-Man*'s Inconsistent Policy Rationales Cannot Justify Its A-Textual Approach	18

TABLE OF CONTENTS – Continued

Page

C. There Is No Basis For *Yard-Man*'s Presumption In This Court's Precedents 22

II. The Vesting Of Health-Care Benefits Must Be Clear And Express In The Language Of The Agreement 25

III. Alternatively, There Must Be Language In The Agreement Capable Of Being Reasonably Interpreted As A Promise Of Vesting 30

IV. Under Any Meaningful Standard, The Sixth Circuit's Judgment Cannot Stand ... 34

A. Durational Language In The Operative Agreements Indicates That The Health-Care Benefits Were To End With Those Agreements 34

B. When The Parties Intended Benefits To Vest, They Adopted Specific Language To Accomplish That Intention 36

C. The Power Of The *Yard-Man* Presumption Is Apparent In Its Ability To Overcome Plain Contractual Language..... 38

Conclusion..... 43

TABLE OF AUTHORITIES

Page

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TABLE OF AUTHORITIES – Continued

Page

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Litton v. *NLRB*, 501 U.S. 190 (1991) 12, 17, 31

Maurer v. *Joy Techs., Inc.*, 212 F.3d 907 (6th Cir. 2000) 10

Moore v. *Metro. Life Ins. Co.*, 856 F.2d 488 (2d Cir. 1988) 5, 6

Noe v. *Polyone Corp.*, 520 F.3d 548 (6th Cir. 2008) 21, 38, 42

Orff v. *United States*, 358 F.3d 1137 (9th Cir. 2004) 26

Raffles v. *Wichelhaus*, 2 H. & C. 906, 159 Eng. Rep. 375 (ex. 1864) 32

Reese v. *CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) 24

TABLE OF AUTHORITIES – Continued

Page

Republic Steel Corp. v. *Maddox*, 379 U.S. 650 (1965) 3

Rossetto v. *Pabst Brewing Co.*, 217 F.3d 539 (7th Cir. 2000) ..... *passim*

Schonholz v. *Long Island Jewish Med. Ctr.*, 87 F.3d 72 (2d Cir. 1996) 30

Sengpiel v. *B.F. Goodrich Co.*, 156 F.3d 660 (6th Cir. 1998) 24

Senior v. *NSTAR Elec. & Gas Corp.*, 449 F.3d 206 (1st Cir. 2006) 40

Smith v. *Evening News Ass'n*, 371 U.S. 195 (1962) 28, 33

Standard Oil Co. v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981) 5

Stolt-Nielsen S.A. v. *AnimalFeeds Int'l Corp.*, 559 U.S. 662 (2010) 16

Textile Workers Union of Am. v. *Lincoln Mills of Ala.*, 353 U.S. 448 (1957) 3, 15

Transp.-Commc'n Emps. Union v. *Union Pac. R.R.*, 385 U.S. 157 (1966) 15

United Paperworkers Int'l Union v. *Champion Int'l Corp.*, 908 F.2d 1252 (5th Cir. 1990) 40

US Airways, Inc. v. *McCutchen*, 133 S. Ct. 1537 (2013) 14, 16

USW v. *Connors Steel Co.*, 855 F.2d 1499 (11th Cir. 1988) 34

TABLE OF AUTHORITIES – Continued

Page

Wise v. *El Paso Nat. Gas Co.*, 986 F.2d 929 (5th Cir. 1993) 5

Yolton v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006) 25

STATUTES

Internal Revenue Code (26 U.S.C.) §§ 106, 162 22

28 U.S.C. § 1254(1) 1

Labor Management Relations Act of 1947 (LMRA), 29 U.S.C. § 141 *et seq.*

Section 8, 29 U.S.C. § 158 3

Section 201, 29 U.S.C. § 171 (Taft-Hartley Act) 29

Section 301, 29 U.S.C. § 185 ..... 1, 3, 8, 26

Employee Retirement Income Security Act (ERISA), as amended, 29 U.S.C. § 1001 *et seq.*

Section 3, 29 U.S.C. § 1002 4

Section 201, 29 U.S.C. § 1051 ..... 4, 5, 6

Section 203, 29 U.S.C. § 1053 4

Section 302, 29 U.S.C. § 1082 4

Section 303, 29 U.S.C. § 1083 4

Section 304, 29 U.S.C. § 1084 4

Section 404, 29 U.S.C. § 1104 23

Section 502, 29 U.S.C. § 1132 ..... 1, 8

TABLE OF AUTHORITIES – Continued

Page

29 U.S.C. § 1144 (1974) 5

29 U.S.C. § 1202 (1974) 22

OTHER AUTHORITIES

A. FARNSWORTH, CONTRACTS §§ 3.1, 3.3 (1982).....16

ANTONIN SCALIA, A MATTER OF INTERPRETATION 29 (1997).....26

Gregory Parker Rogers, *Rethinking* Yard-Man: *A Return to Fundamental Contract Principles in Retiree Benefits Litigation*, 37 Emory L.J. 1033 (1988) 20

H. Rep. No. 807, 93d Congr., 2d Sess. 60, reprinted in 1974 U.S. Code Cong. & Admin. News 4670 6

OPINIONS AND ORDERS BELOW

The order of the court of appeals denying *en banc* rehearing (Pet. App. 148-49), is unreported. The panel opinion (Pet. App. 1-23), is reported at 733 F.3d 589 (6th Cir. 2013) ("*Tackett II*"). The opinion and order of the district court (Pet. App. 24-87) is reported at 853 F. Supp. 2d 697 (S.D. Ohio 2012). The Sixth Circuit's previous opinion (Pet. App. 88-121), is reported at 561 F.3d 478 (6th Cir. 2009) ("*Tackett I*"). The district court's original opinion and order (Pet. App. 121-47), is reported at 523 F. Supp. 2d 684 (S.D. Ohio 2007).

STATEMENT OF JURISDICTION

The court of appeals filed its order denying *en banc* rehearing on October 22, 2013. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of § 301 of the Labor Management Relations Act (LMRA), 29 U.S.C. § 185, and ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), are set forth at Pet. App. 150-52.

STATEMENT

When employees and unions bargain with employers for retiree health-care benefits, those benefits—and the conditions for receiving them—are set out in collective bargaining agreements. Those agreements virtually never specify the duration of the benefits. And as a general rule, the obligations set out in a collective bargaining agreement end when the agreement itself terminates.

Nonetheless, the Sixth Circuit in this case applied its "presum[ption] that the parties intended retiree welfare benefits to continue for life, notwithstanding the expiration of [the] collective bargaining agreement." See *Int'l Union, UAW* v. *Skinner Engine Co.*, 188 F.3d 130, 140 (3d Cir. 1999). The court of appeals thus held that the collective bargaining agreements at issue here vested retirees with a right to lifetime, contribution-free health-care benefits, even though no affirmative language indicated such an intent.

In reaching that conclusion, the Sixth Circuit applied what is known as its "*Yard-Man* presumption"—created by that court in *International Union, United Automobile, Aerospace, & Agricultural Implement Workers of America* v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983). The *Yard-Man* presumption (or inference) is an aberration that cannot be justified as a matter of contract interpretation or labor law. It lacks any statutory basis and runs directly counter to Congress' intent "not to provide for the vesting of employee welfare benefits." *Skinner*, 188 F.3d at 141. And it is wholly unnecessary, as

"those who fear that their unions will not bargain for continued benefits for retirees need only see to it that specific vesting language protecting those benefits is incorporated into collective bargaining agreements." *Ibid.* This Court should reject *Yard-Man*, require at least some affirmative indication in the language of the agreement that the parties to a collective bargaining agreement intend to vest retiree health-care benefits in perpetuity, and reverse the contrary judgment below.

A. Background

Where employees are represented by a union, it will negotiate with their employer to establish working conditions, safety measures, wages, hours, and seniority rules, among other things. See 29 U.S.C. § 158(d); *Fibreboard Paper Prods. Corp.* v. *NLRB*, 379 U.S. 203, 209-10 (1964). The terms reached through the negotiations are memorialized in a collective bargaining agreement, which is a contract between the union and the employer that serves, in turn, as the foundation for the relationship between unionized employees and their employer. See 29 U.S.C. § 185(a); *Republic Steel Corp.* v. *Maddox*, 379 U.S. 650, 657 (1965); *Textile Workers Union of Am.* v. *Lincoln Mills of Ala.*, 353 U.S. 448, 454 (1957).

Fringe benefits for unionized employees may be set forth in the collective bargaining agreement itself or in a separate document that is incorporated into and becomes part of the agreement. In some industries,

such as the rubber industry in this case, employers and unions historically negotiate a pension and insurance agreement ("P&I agreement") for this purpose. This is a separate contract that is incorporated by reference into the collective bargaining agreement and details both pension benefits and welfare benefits available to eligible union members. Welfare benefits include such things as life insurance coverage, disability benefits, supplemental workers' compensation, dental and vision care, health-care benefits, and severance benefits.

Since the Employee Retirement Income Security Act (ERISA) was enacted in 1974, "employee pension benefit plan[s]" have been treated differently from "employee welfare benefit plan[s]," including health benefits. Compare 29 U.S.C. § 1002(2)(A), with § 1002(1). For the former category, Congress created elaborate vesting, accrual, participation, and minimum funding requirements that cannot be bargained away. *Id.* §§ 1053, 1082, 1083, & 1084. For the latter category, Congress quite deliberately took a different approach in providing that welfare benefits do not vest by law and are not subject to accrual, participation, and funding rules. See *id.* § 1051(1) (exempting "employee welfare benefit plan[s]" from the pension vesting rules set forth at § 1053).

Thus ERISA establishes no "minimum * * * vesting requirements for welfare plans as it does for pension plans," and as a result, employers are "generally free * * * for any reason at any time to adopt, modify, or terminate welfare plans." *Curtiss-Wright*

Corp. v. *Schoonejongen*, 514 U.S. 73, 78 (1995); see also 29 U.S.C. § 1051 (ERISA's vesting, participation, and anti-cutback provisions do not apply to "employee welfare benefit plan[s]"). Employers may nonetheless choose to vest health and welfare benefits. *Skinner*, 188 F.3d at 138 (employers may "relinquish their right to unilaterally terminate those benefits and provide for lifetime vesting").

Further, because ERISA preempts state law, there is no room for states to amend Congress' design. 29 U.S.C. § 1144(a) (1974). Thus state law cannot force an employer to establish a benefit plan, *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11-12 (1987), and, most pertinent here, cannot force the vesting of health-care benefits. *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981).

"The disparate treatment" Congress has "accorded welfare plans" as opposed to pension plans "is not accidental." *Wise* v. *El Paso Nat. Gas Co.*, 986 F.2d 929, 935 (5th Cir. 1993). It reflects the reality that pension plans are qualitatively different than welfare plans. That is, the future expense of pension plans, typically paid as fixed annuities, is based on relatively stable data and can be calculated with a high degree of actuarial certainty. *Moore* v. *Metro. Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). In contrast, health-insurance costs vary dramatically based on inflation, changes in medical practice, claims history, and other factors that are notoriously unpredictable. *Ibid.* Those "unstable variables prevent accurate

prediction of future needs and costs" and dictate that employers be given significant latitude in granting health-related benefits. *Ibid.*; see also 29 U.S.C. § 1051. By exempting welfare benefits from vesting requirements, Congress recognized that employers and employees alike benefit from greater flexibility in responding to the ever-changing marketplace for health benefits.

The different treatment Congress accorded welfare and pension benefits also reflects the reality that imposing vesting requirements increases plan administration burdens and costs. *Hozier* v. *Midwest Fasteners, Inc.*, 908 F.2d 1155, 1160 (3d Cir. 1990). Although Congress determined those burdens and costs were warranted with respect to pension benefits, it did not view welfare benefits the same way. See, e.g., H. Rep. No. 807, 93d Congr., 2d Sess. 60, reprinted in 1974 U.S. Code Cong. & Admin. News 4670, 4726 ("To require the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income."). Congress thus "balance[d] its desire to regulate extant plans more extensively against the danger that increased regulation would deter employers from creating such plans in the first place." *Hozier*, 908 F.2d at 1160.

B. Facts and Procedural History

Since 2000, M&G has operated a chemical plant in Apple Grove, West Virginia. Before that, Goodyear

and Shell operated the plant and employed its workers. Pet. App. 3. As relevant here, the local union and the employers negotiated a series of five collective bargaining agreements to govern the relationship between the workers and their employers at the plant.

Along with the collective bargaining agreements, the parties negotiated P&I agreements detailing the pension benefits and welfare benefits available to eligible union members. *Id.* at 3-7. The P&I agreements were initially negotiated between the International union and the employers, and then adopted by the local union through the collective bargaining agreements. *Id.* at 3-4. Each P&I agreement included explicit durational limits that specifically applied to the health-care benefits described therein.[1]

In addition to the P&I agreements, the International union negotiated side agreements—known as "cap" agreements—obligating retirees to make contributions toward their health-care costs to the extent those costs exceeded the cap. *Id.* at 32-34.[2]

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[1] See, e.g., JA 33, 44 ("Effective January 1, 1992 *and for the duration of this Agreement thereafter*, the Employer will provide" the health-care benefits described. (emphasis added)).

[2] See, e.g., JA 436 ("If the average annual cost of health care benefits for each such group described in paragraph 1 above exceeds the specified amount, the cost in excess of that amount shall be allocated evenly to all retired employees (including surviving spouse) in such group."). In the courts below, the parties vigorously disputed the extent to which the cap agreements applied, but that dispute is not relevant to the issue before the Court.

In 2006, M&G informed retirees from the West Virginia plant that they would be required to contribute to their health-care costs. *Id.* at 139. This class action followed. Plaintiffs—the International union and retirees residing in Ohio, within the Sixth Circuit—asserted three claims: (1) violation of labor agreements, actionable under LMRA § 301(a), 29 U.S.C. § 185(a) (Count I); (2) violation of employee welfare benefit plans, actionable under ERISA §§ 502(a)(1)(B) & (a)(3), 29 U.S.C. §§ 1132(a)(1)(B) & (a)(3) (Count II); and (3) breach of fiduciary duty under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (Count III). *Id.* at 123 & 140. The union and the plaintiff retirees alleged they had a right to vested, lifetime health-care benefits without any contributions on their part on account of language in some of the P&I agreements referring to a "full Company contribution towards the cost of benefits." *Id.* at 140.[3]

Initially, the district court granted M&G's motion to dismiss all three claims as a matter of law. *Id.* at 146-47. In the district court's view, the absence of language in the collective bargaining agreements specifying vesting, combined with the cap agreements, unambiguously fixed the amount M&G was obligated to contribute toward retiree health-care benefits and permitted retiree contributions. *Id.* at

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[3] The "full Company contribution" language only appears in three of the five agreements at issue. JA 134, 189 (1994 P&I Agreement); *id.* at 263 (1997 P&I Agreement); *id.* at 415 (2000 P&I Agreement).

143-47. The district court recognized that a promise of a "full Company contribution" said nothing about the duration of the available benefits—or that the total costs would be paid fully by M&G—and ruled in its favor on the vesting question as a matter of law. *Id.* at 142-43 ("'[A] full Company contribution' is consistent with caps." (alteration in original)). The retirees and the union appealed.

The Sixth Circuit reversed in part, concluding that the retirees sufficiently pleaded an intention to vest health-care benefits to survive a motion to dismiss, and remanded for further proceedings. *Id.* at 90. In reaching that conclusion, the Sixth Circuit relied heavily on *Yard-Man*, which presumes that retiree health-care benefits obtained through a collective bargaining agreement are vested. *Ibid.*

The court of appeals first invoked the "context of the labor-management negotiations identified in *Yard-Man*" to "find it unlikely" that the union would have agreed to non-vested health-care benefits given the promise of a "full Company contribution" in the collective bargaining agreements. *Id.* at 112. The court of appeals also presumed vesting from the location of that promissory language, which followed a provision requiring shorter-tenured employees to make specific contributions to health-care costs. *Ibid.* That led the court to believe that workers who did not have to make these specific contributions were thus guaranteed unalterable benefits for life at no cost to them. *Ibid.*

Further noting that the collective bargaining agreements "tied eligibility for health-care benefits to pension benefits," the court of appeals treated that as an additional factor indicating that vesting was intended. *Ibid.* And so from silence on vesting, the court inferred that the parties really intended for the employer to provide the health-care benefits in perpetuity—a result required, the court made clear, by *Yard-Man*. *Id.* at 113-14 ("When the plan document at issue is a collective bargaining agreement, the interpretative principles outlined in *Yard-Man* govern a court's determination of the parties' intent to vest health-care benefits." (citing *Maurer* v. *Joy Techs., Inc.*, 212 F.3d 907, 917 (6th Cir. 2000))).

Although the Sixth Circuit claimed it was not deciding the ultimate question of vesting, *id.* at 61-62, its opinion was "an unqualified declaration" that "the parties intended health-care benefits to vest." *Id.* at 62; see also *id.* at 111-12 (referring to language in some of the P&I agreements that the employer would make a "full Company contribution" toward the costs of health-care benefits).

On remand, the district court conducted a bench trial on liability and held that the retirees had a right to health-care benefits for life. *Id.* at 25. The bench trial did not establish the vesting of benefits, though—that question had already been answered by the Sixth Circuit when it held that "[a] court may find vested rights 'under a [collective bargaining agreement] even if the intent to vest has not been explicitly

set out in the agreement.'" *Id.* at 58. As the Sixth Circuit itself later recognized, the prior panel decision established "a controlling interpretation of the [collective bargaining agreement] that prove[d] dispositive of at least the vesting issue, if not the issue of capped versus uncapped benefits." *Id.* at 61. The district court's ruling addressed merely "what vested" in concluding that the retirees had a vested right to free health-care benefits for life. The district court issued a permanent injunction barring M&G from collecting contributions from retirees as a condition to the receipt of benefits. *Id.* at 86-87. M&G appealed.

Guided once again by *Yard-Man*, the Sixth Circuit affirmed. The court of appeals approved the district court's presumption that the language in the collective bargaining agreement vested a right to lifetime, contribution-free benefits in the absence of any extrinsic evidence to the contrary. *Id.* at 2-3. Although the cap agreements were potentially extrinsic evidence against vesting, the court of appeals agreed with the district court that they were insufficient to counter the retirees' argument once vesting was assumed. *Id.* at 22.

The Sixth Circuit denied M&G's petition for rehearing *en banc*. *Id.* at 148-49.

SUMMARY OF ARGUMENT

Under ordinary rules of contract interpretation, the language of the agreement is paramount and extrinsic evidence is used only to clarify ambiguity, never to create it. Here, the Sixth Circuit disregarded those rules of interpretation and applied a presumption in favor of benefit vesting so strong it overcame both an unambiguous contract and unassailable extrinsic evidence that rebutted any presumption of vesting. It therefore is unsurprising that petitioners would have prevailed in any circuit—and under any standard—that does not presume or imply contractual obligations to retirees. The decision below should be reversed.

The Sixth Circuit's error came in using the *Yard-Man* presumption that relies on the context of retiree health-care—rather than the text of the operative agreement—to establish vesting. The court first assumed unvested benefits were unlikely and then set out to justify that conclusion by seizing on the "full Company contribution" language. That language, however, says nothing about the duration of the health-care benefits. The lack of a durational term in the collective bargaining agreement hardly makes it ambiguous. In the bargaining context, benefits are well known to expire with the agreement that provides them. *Litton* v. *NLRB*, 501 U.S. 190, 207-08 (1991).

Yet *Yard-Man* evidently demands that an employer expressly deny vesting of retiree benefits if

those benefits are to end with the collective bargaining agreement. And so in addition to disregarding the normal rules of contract interpretation, the Sixth Circuit's presumption also ignores Congress' deliberate policy choice not to require vesting of retiree health-care benefits (as opposed to pension benefits). *Yard-Man*'s "inference" concerning an extra-textual obligation cannot be correct.

The legal standards for making vesting determinations applied in other circuits, however, both conform with ordinary rules of contract interpretation and facilitate national labor policy instead of working against it. The Third Circuit uses what has been called a "clear statement rule" that requires any claim of vesting to be based on an express statement in the agreement to that effect. At the same time, the Second and Seventh Circuits hold that a collective bargaining agreement must have at least some language indicating an intent for the health-care benefits to vest.

While some might argue that such text-based rules operate as a presumption *against* vesting, there is, in reality, no thumb on the scale either way in these circuits. Given the background rule that benefits cease with the termination of the collective bargaining agreement unless otherwise provided, the ordinary rules of contract interpretation would require any promise of vesting to be explicit in the language of the agreement. That requirement of affirmative vesting language—something beyond mere silence on the duration of the benefit—allows

the burden of proof to remain with the plaintiff who is, after all, the one invoking vesting. A rule that allows the parties to rely on the language of the agreement that binds them is no presumption. It is simply an ordinary rule of contract interpretation. See, e.g., *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1548-49 (2013) (explaining that in construing contracts, courts look to the terms of the plan, consider the parties' intent, and when appropriate take account of the governing background rules).

Whatever the precise contours of the legal standards applied by the Second, Third, and Seventh Circuits, petitioners would have prevailed there and in any circuit not predisposed to find vesting. Language in the P&I agreements at issue indicated that the benefits provided therein would expire when the governing documents did. The only exceptions—and there were several—would necessarily be indicated in the contract. In describing pension benefits, for instance, the P&I agreements acknowledged that they could not be reduced and that certain amounts were vested according to various schedules. In contrast, the retiree health-care provisions contained no durational language even arguably vesting the benefits. Absent such language, any contractual obligations regarding the retiree health-care benefits last only so long as the collective bargaining agreement—or another one replacing it—is operative.

The fact that the Sixth Circuit ignored that evidence only confirms the power (and error) of its *Yard-Man* presumption. It also underscores the need for a rule that establishes a uniform requirement of textual clarity in establishing employer obligations in collective bargaining agreements where the duration of retiree health-care benefits is concerned. Otherwise, courts will continue to enact their own policy preferences under the guise of "ordinary" contract construction that is anything but. This Court should reject the *Yard-Man* presumption, clarify that at least some affirmative indication of vesting is required in the language of collective bargaining agreements, and reverse the judgment below.

ARGUMENT

I. THE SIXTH CIRCUIT'S *YARD-MAN* PRESUMPTION VIOLATES ORDINARY RULES OF CONTRACT INTERPRETATION, CONFLICTS WITH CONGRESSIONAL INTENT, AND DISSERVES NATIONAL LABOR POLICY

This Court has held that collective bargaining agreements should be construed by applying ordinary rules of contract interpretation when not inconsistent with federal labor policy. *Transp.-Commc'n Emps. Union* v. *Union Pac. R.R.*, 385 U.S. 157, 160-61 (1966); *Textile Workers*, 353 U.S. at 456. Neither ordinary rules of contract interpretation nor federal labor policy support—much less require—the Sixth

Circuit's *Yard-Man* presumption that contractual silence means that retiree health benefits have vested.

A. Health-Care Benefits Granted Without A Durational Clause Or Vesting Guarantee Terminate With The Agreement That Provides Them

Contract interpretation, like statutory analysis, begins with the agreement's plain language. *McCutchen*, 133 S. Ct. at 1548-49. That is because there is no more reliable indicator of the parties' intent—which is the touchstone of the analysis—than the words they chose to express that intent. See, e.g., *Stolt-Nielsen S.A.* v. *AnimalFeeds Int'l Corp.*, 559 U.S. 662, 682 (2010). And without a clear intent on the face of the agreement to confer certain benefits, contracts are not understood to provide them. A. FARNSWORTH, CONTRACTS §§ 3.1, 3.3 (1982).

In this case, it is undisputed that the collective bargaining agreements did not specify the duration of the retiree health-care benefits provided by the company separately from the duration of the agreements themselves. Contrary to the Sixth Circuit's approach, however, that contractual silence as to duration did not give the court of appeals license to violate the normal rules of contract interpretation by effectively rewriting the agreement to provide vested benefits that the parties neither bargained for nor specified in the language of the agreement itself.

Two bedrock principles reinforce that conclusion. First, Congress has established the default rule that employers are "generally free * * * for any reason at any time, to adopt, modify or terminate welfare plans." *Schoonejongen*, 514 U.S. at 78. Second, this Court has held that when a collective bargaining agreement expires, its provisions do too. *Litton*, 501 U.S. at 207-08 (holding that "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement" unless the "collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration"). Both principles flatly contradict the Sixth Circuit's view that silence on the duration of benefits creates ambiguity in a collective bargaining agreement.

To be sure, negotiated provisions in a collective bargaining agreement may outlive the agreement—if the parties so provide. See *John Wiley & Sons, Inc.* v. *Livingston*, 376 U.S. 543, 554-55 (1964). But that intention must be clearly spelled out in the agreement itself. *Ibid.*; *Litton*, 501 U.S. at 207-08 (holding that obligations survive the termination of the agreement if it "provides in *explicit* terms that certain benefits continue after the agreement's expiration" (emphasis added)). That is plainly not the case here. As a result, under the normal rules of contract interpretation as informed by national labor policy, the benefits at issue either expired at the end of the agreement or were permissibly alterable by M&G based on other agreements between the parties.

The Sixth Circuit, however, reached precisely the opposite conclusion—construing the absence of any durational term for retiree health-care benefits in the agreement to allow an inference that the parties meant for health-care benefits to be vested for life. That holding became the basis for the district court's subsequent finding that the negotiated caps on employer contributions could not be enforced. Thus, the root of the problem is the Sixth Circuit's previous decision in *Yard-Man*.

B. *Yard-Man*'s Inconsistent Policy Rationales Cannot Justify Its A-Textual Approach

In *Yard-Man*, the plaintiff retirees and their union brought suit when a factory closed and the company informed the union that retiree health benefits would end when the collective bargaining agreement expired. As here, the agreement was silent on the duration of benefits. The Sixth Circuit determined, however, that extrinsic evidence should be used to resolve the purported "ambiguity" because, according to the court, "when the parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." *Yard-Man*, 716 F.2d at 1482.

The *Yard-Man* court offered two policy reasons to justify its presumption of vesting. First, because

retiree benefits are based on a recipient's "status" as a retiree, they should continue as long as the recipient remains a retiree. *Ibid.* Second, because welfare benefits are a permissive subject of bargaining—and thus unions do not have to defend the retirees' rights once the retirees are no longer part of the bargaining unit—there must be a presumption in favor of vesting to protect the group that is no longer in a position to bargain with the employer. *Ibid.* Even assuming policy arguments like these could ever justify the Sixth Circuit's departure from the normal rules of contract interpretation, both fail on their own terms.

First, the notion that courts should deem healthcare benefits to vest merely because they were granted to retirees (i.e., the "status" rationale) finds no support in law or logic. Of course retiree medical benefits are tied to an employee's status as a retiree—that is their purpose. But that temporal link does not establish that pension benefits and welfare benefits are equivalent in terms of their duration and mutability.

Second, the permissive-bargaining rationale overlooks the interest of the unions in ensuring the protection of their former members. After all, today's active employees are tomorrow's retirees. Unions and employees are well aware that these types of benefits are constantly up for negotiation and revision. If a party desired (and were able) to secure such benefits in perpetuity, no matter the cost, language confirming such an extraordinary allowance would be easy

enough to draft. See Gregory Parker Rogers, *Rethinking* Yard-Man: *A Return to Fundamental Contract Principles in Retiree Benefits Litigation*, 37 Emory L.J. 1033, 1067 (1988) ("If the union was serious about getting benefits for its retirees beyond the end of the contract as 'deferred compensation,' then almost certainly it would demand a clause in the collective bargaining agreement to that effect.").

Moreover, the permissive-bargaining rationale ignores the reality that unions frequently do negotiate over the health benefits of current retirees. *Ibid.* The instant case proves the point. Over the course of 15 years, the union and the company negotiated cap agreements that explicitly altered the terms of current retirees' health benefits. Pet. App. 38-51.[4]

Otherwise, given the baseline rule that the terms of collective bargaining agreements expire when the agreement does (absent an express textual indicator to the contrary), the parties have no need to separately and explicitly address the duration of benefits. If the parties want a term renewed, they can negotiate for it to become part of the next agreement. In the absence of any separate durational term concerning medical benefits, then, ordinary principles of contract

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[4] The existence of retiree benefits as a mandatory subject of bargaining here—adopted at least as recently as the fifth collective bargaining agreement, JA 441—only confirms the error of the *Yard-Man* rationale that retirees need vested benefits because no one will negotiate on their behalf after retirement.

interpretation dictate that the parties did not intend the benefits to extend beyond the termination of the contract, much less to vest.

But in the Sixth Circuit, the opposite is true—"[u]nless a company can point to explicit language in the relevant agreement stating that 'retiree benefits' terminate at a particular date or do not vest, the benefits seem to vest as a matter of law." *Noe* v. *Polyone Corp.*, 520 F.3d 548, 568 (6th Cir. 2008) (Sutton, J., concurring in part and dissenting in part). Employers sued in the Sixth Circuit are left trying to prove a negative when, if anything, "a reversal of [the Sixth Circuit's] presumptions would make better sense—that if the union negotiated for such rights, they would surely appear in the collective bargaining agreement." *Rossetto* v. *Pabst Brewing Co.*, 217 F.3d 539, 543-44 (7th Cir. 2000) (Posner, J.).

By requiring defendant employers to be clear when *not* desiring a benefit to vest, the Sixth Circuit reverses the burdens of proof not only in contract interpretation but also in litigation generally. After all, it is the union or the retirees—not the employer—that bears the burden of proof in these cases to establish vested benefits. See, e.g., *Howe* v. *Varity Corp.*, 896 F.2d 1107, 1109 (8th Cir. 1990). Employers should not be left trying to prove a negative.[5]

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[5] The *Yard-Man* court professed to "agree" that "traditional rules of contractual interpretation require a clear manifestation of intent before conferring a benefit or obligation" but

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That may be why Judge Easterbrook, writing in favor of a strong presumption against vesting, suggested that "as the duration and cost of the supposed promise increase," so too should "the level of formality required to conclude that a promise exists." *Bidlack* v. *Wheelabrator Corp.*, 993 F.2d 603, 618 (7th Cir. 1993) (en banc) (Easterbrook, J., dissenting). That conclusion necessarily follows from the logic that an employer would have thought long and hard before committing itself to providing health-care benefits in perpetuity (and with no additional contributions from former employees). That is especially true given that, unlike pension obligations that are typically fixed for the retiree's life, health-care obligations are virtually unlimited.

C. There Is No Basis For *Yard-Man*'s Presumption In This Court's Precedents

As explained *supra* at 4-6, Congress chose to provide employers with the flexibility to adapt welfare benefits—like health benefits—to rapidly escalating costs. See 29 U.S.C. § 1202(c) (1974); see also I.R.C. §§ 106, 162 (incentivizing employers to offer health-care benefits by providing generous tax breaks, but not mandating vesting). The Sixth Circuit's *Yard-Man* presumption upsets that balance by

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disagreed—with no citation of authority or elaboration—"that the duration of the benefit once clearly conferred is subject to this stricture." 716 F.2d at 1481 n.2.

fixing collectively bargained health-care benefits at the point of retirement, and erases the distinction Congress has drawn between welfare benefits (including health-care benefits) and pension benefits.

This Court's recent decision in *Fifth Third Bancorp* v. *Dudenhoeffer*, 134 S. Ct. 2459 (2014), is instructive. There, the Court rejected a judicially created presumption arising under Section 404(a)(1)(B) of ERISA that an employer acts prudently when making decisions about the employer's securities (e.g., whether or not to buy or sell) in an ERISA pension plan. *Id.* at 2467. Virtually all of the courts of appeals applied the presumption to impose a higher burden of proof on plaintiffs alleging that an employer's failure to dispose of the employer stock in the face of declining markets (or other company-specific events) was a breach of the duty of prudence under Section 404(a)(1)(B). *Ibid.* This Court rejected the presumption of prudence, emphasizing that ERISA § 404(a)(2), one of the purported bases for the presumption, "makes no reference to a special 'presumption' in favor of ESOP [employee stock ownership plan] fiduciaries." *Ibid.*

Here, there is not even an arguable statutory basis for the Sixth Circuit's *Yard-Man* presumption—and the Sixth Circuit has never claimed otherwise. Nor is there anything approaching the uniformity with which the courts of appeals embraced the presumption of prudence in favor of ESOP fiduciaries. To the contrary, the Sixth Circuit is an outlier in that regard. Pet. 10-17. By comparison, the *Yard-Man*

presumption rests on even shakier ground than the presumption of prudence this Court unanimously rejected in *Fifth Third*. The *Yard-Man* presumption should likewise be dispatched.

In applying that presumption, the Sixth Circuit is not only wrong but also internally inconsistent. The court unabashedly admits that its "*Yard-Man* test applies to claims for benefits that arise out of a [collective bargaining agreement]," and not "to cases in which an employer unilaterally instituted a retiree benefit program." *Reese* v. *CNH Am. LLC*, 574 F.3d 315, 328 (6th Cir. 2009) (internal citations omitted); see also *Sengpiel* v. *B.F. Goodrich Co.*, 156 F.3d 660, 667 (6th Cir. 1998) (holding that where benefits are not collectively bargained, the employer may alter or even terminate the benefits unless the plan documents prohibit the changes "in clear and express language"). That is inconsistent with simple logic, which would suggest that if interpretive presumptions were legitimate—a scenario recently rejected by *Fifth Third*—it should be an unrepresented retiree that benefitted from the extra-textual protection. *Rossetto*, 217 F.3d at 543-44 (Posner, J.).

No one can disagree with Judge Sutton that, at times, the "precise weight of the *Yard-Man* 'inference' * * * is elusive." *Reese*, 574 F.3d at 321. The *Yard-Man* presumption obviously does not mean that the employer loses in every case. What it does mean, though, is that employers lose unless there is an explicit *denial* of vesting *and* health-care benefits are not linked to retirement (which is, given the

background rules discussed above, virtually never the case). See, e.g., *Yolton* v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 583 (6th Cir. 2006); *Golden* v. *Kelsey-Hayes Co.*, 73 F.3d 648, 656-57 (6th Cir. 1996).

Yard-Man thus wrongly implies contractual obligations from silence to create liability where none originally existed. In doing so, it violates the ordinary rules of contract interpretation and upsets Congress' careful balancing of interests in distinguishing between pension and welfare benefits—all without any statutory basis whatsoever. This Court should reject the *Yard-Man* presumption in no uncertain terms, just as it did the presumption at issue in *Fifth Third*.

II. THE VESTING OF HEALTH-CARE BENEFITS MUST BE CLEAR AND EXPRESS IN THE LANGUAGE OF THE AGREEMENT

In contrast to the Sixth Circuit's a-textual approach, the Third Circuit's requirement of a clear, express statement that the parties intended for health-care benefits to vest—i.e., to extend beyond the term of the agreement—comports with ordinary rules of contract interpretation, offends no policy of federal labor law, and tracks the congressional assessment under ERISA that welfare benefits should not vest unless there is an express agreement that they should. See *Skinner*, 188 F.3d at 139 ("Because vesting of welfare plan benefits constitutes an extra-ERISA commitment, an employer's commitment to

vest such benefits is not to be inferred lightly and must be stated in clear and express language.").[6]

The Third Circuit adopted its clear statement rule in *UAW* v. *Skinner Engine Corp.* The plaintiffs there brought a § 301 action after the company altered a number of welfare benefits related to life and health. *Id.* at 136-37. The Third Circuit expressly declined to follow *Yard-Man*, *id.* at 139, relying instead on Congress' explicit exemption of welfare benefits from ERISA's vesting requirements. The court concluded that it is "illogical to infer an intent to vest welfare benefits in every situation where an employee is eligible to receive them on the day he retires" and that it is "not at all inconsistent with labor policy to require plaintiffs to prove their case without the aid of gratuitous inferences." *Id.* at 141.

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[6] Far from being a thumb on the scales in favor of employers, the Third Circuit's clear statement rule is analytically similar to like rules applied in other contracting contexts, such as the requirement of "precise language of the contract for a 'clear intent' to rebut the presumption that [third parties] are merely incidental beneficiaries" of government contracts. See, e.g., *Orff* v. *United States*, 358 F.3d 1137, 1147 n.5 (9th Cir. 2004); cf. ANTONIN SCALIA, A MATTER OF INTERPRETATION 29 (1997) (observing in the context of statutory construction that "[s]ome of the rules, perhaps, can be considered merely an exaggerated statement of what normal, no-thumb-on-the-scales interpretation would produce anyway. For example, since congressional elimination of state sovereign immunity is such an extraordinary act, one would normally expect it to be explicitly decreed rather than offhandedly implied—so something like a 'clear statement' rule is merely normal interpretation.").

The Third Circuit similarly rejected the Sixth Circuit's rationale that a presumption in favor of vesting is justified because the benefits are a subject of permissive collective bargaining. *Ibid.* Rather, as the Third Circuit observed, "those who fear that their unions will not bargain for continued benefits for retirees need only see to it that specific vesting language protecting those benefits is incorporated into collective bargaining agreements." *Ibid.* (quoting *Bidlack*, 993 F.2d at 609 (Posner, J., plurality opinion)).

After rejecting the *Yard-Man* approach, the Third Circuit turned to the language of the agreement. Though the agreement described the benefits at issue using terms such as "will continue" and "shall remain," the Third Circuit reasoned that those terms did not "clearly and expressly indicate vesting since there is simply no durational language to qualify" them. *Ibid.* The court noted that extrinsic evidence can be used to clarify contracts, but only when there is actual ambiguity. *Id.* at 145. "Silence on duration, however, may not be interpreted as an agreement by the company to vest retiree benefits in perpetuity." *Id.* at 147.

That rule—covering the exact situation here—is correct, comports with ordinary rules of contract interpretation, and offends no labor policy. It aligns with normal contract interpretation far more than looking to infer the parties' intent and presuming it from either silence or the "context" of the agreement, as the Sixth Circuit does. And it manifests the same

healthy skepticism with which extra-textual claims of ambiguity are greeted in contract interpretation generally. After all, the parol evidence rule exists for good reason.

The familiar maxim that contract interpretation (like statutory interpretation) generally begins (and frequently ends) with the language of the agreement applies with special force here, where certainty is important to both employers and retirees about whether collective bargaining agreements provide for vested health-care benefits. In that respect, the Third Circuit's clear statement rule is entirely consistent with national labor policy in that, as this Court has observed, "the administration of collective bargaining contracts [is to be] accomplished under a uniform body of federal substantive law." *Smith* v. *Evening News Ass'n*, 371 U.S. 195, 200 (1962). A clear statement rule is best suited to provide that uniformity and certainty.[7]

Further, allowing employers to require individuals to contribute some amount toward their health-care costs (where, as here, there is no clear and express statement of vesting in the collective bargaining agreement) furthers national labor policy by enabling employers to continue providing health-care benefits without turning those benefits into a crushing liability. In contrast, the Sixth Circuit's contrary

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[7] A clear statement rule also comports with Congress' policy choices under ERISA. *Supra* at 4-6.

rule may actually disserve national labor policy by discouraging employers from continuing to provide post-retirement medical coverage to current employees altogether to avoid that liability.

A clear statement rule would further national labor policy in yet another way by almost certainly reducing litigation and encouraging the resolution of labor issues at the collective bargaining table, not the courthouse. See 29 U.S.C. § 171(a) (Taft-Hartley Act) ("It is the policy of the United States that—(a) sound and stable industrial peace and the advancement of the general welfare, health, and safety of the Nation and of the best interest of employers and employees can most satisfactorily be secured by the settlement of issues between employers and employees through the processes of conference and collective bargaining between employers and the representative of their employees * * * .").

Requiring the language of collective bargaining agreements to clearly establish legal obligations furthers national labor policy goals and should be encouraged. This Court should therefore embrace the Third Circuit's rule that "[s]ilence on duration * * * may not be interpreted as an agreement by the company to vest retiree benefits in perpetuity." *Skinner*, 188 F.3d at 147. Instead, a clear and express contractual statement is required. Because there is unquestionably no such statement here, the Sixth Circuit's judgment should be reversed.

III. ALTERNATIVELY, THERE MUST BE LANGUAGE IN THE AGREEMENT CAPABLE OF BEING REASONABLY INTERPRETED AS A PROMISE OF VESTING

Although they do not require a clear and express statement of vesting as the Third Circuit does, the Second and Seventh Circuits still require that to reach a fact-finder, a plaintiff must be able to "point to written language capable of reasonably being interpreted as creating a promise" to vest the benefits. *Am. Fed'n of Grain Millers, AFL-CIO* v. *Int'l Multifoods Corp.*, 116 F.3d 976, 980 (2d Cir. 1997) (quoting *Schonholz* v. *Long Island Jewish Med. Ctr.*, 87 F.3d 72, 78 (2d Cir. 1996)); see *Rossetto*, 217 F.3d at 544. The judgment below cannot stand under that legal standard either.

For example, in *Joyce* v. *Curtiss-Wright Corp.*, 171 F.3d 130, 134 (2d Cir. 1999), the Second Circuit (like the Third Circuit in *Skinner*) held that language stating benefits "will be provided for employees receiving or becoming entitled to receive pension payments" did not create ambiguity concerning the vesting of benefits. Likewise, language in the agreement concerning the termination of the various benefits at potential future dates beyond the collective bargaining agreement could not "reasonably be read as binding [the employer] to vest the benefits at issue" because (as in the case at bar) there was only silence with regard to duration. *Ibid.* Ultimately, without "language that affirmatively operates to create the promise of vesting," the Second Circuit

declined to read such a promise into the agreement. *Id.* at 135.

The Second Circuit acknowledged that, while "context surely matters in the [vesting] analysis, at root the text itself must create a disputed question of fact as to vesting." *Ibid.* (citing *Bidlack*, 993 F.2d at 605-08 (Posner, J., plurality opinion) ("[T]here must be either contractual language on which to hang the label of ambiguous or some yawning void.")). It is not enough to point to silence concerning the duration of a benefit when benefits are expected to terminate at the end of the agreement. See *Litton*, 501 U.S. at 207-08; *Allied Chem. & Alkali Workers* v. *Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971). As a result, the Second Circuit reasoned that "absence of language in the [agreement] flatly *rejecting* the concept of vesting does not alter the retirees' failure to identify language that affirmatively operates to imply vesting." *Joyce*, 171 F.3d at 135.

Similarly, in the Seventh Circuit, a plaintiff must normally show ambiguity in the *language* of the agreement before extrinsic evidence can be used to support a finding of vested benefits. *Rossetto*, 217 F.3d at 544. In *Rossetto*, the plaintiffs sued their former employer for benefits terminated at the conclusion of the operative collective bargaining agreement. The Seventh Circuit recognized that its "en banc decision in *Bidlack* established a presumption that an employee's entitlement to such benefits expires with the agreement creating the entitlement, rather than vesting, but the presumption can be knocked out by a

showing of genuine ambiguity, either patent or latent, *beyond silence*." *Id.* at 543 (emphasis added) (citing *Bidlack*, 993 F.2d at 606-07 (Posner, J., plurality opinion)). The plaintiffs prevailed in *Rossetto*, but only on the basis of a rare "latent ambiguity"—i.e., objectively ambiguous evidence outside the contract language.[8]

Thus in either the Second or the Seventh Circuit, respondents would have been required to identify specific language in the collective bargaining agreements that "affirmatively operates to imply vesting." *Joyce*, 171 F.3d at 135. This they cannot do. In the Sixth Circuit, however, defendants such as petitioners are required to identify particular language *rejecting* vesting. That approach turns ordinary contract principles and proof burdens upside down. Accordingly, this Court should reject the Sixth Circuit's approach and, if it declines to embrace the Third Circuit's clear statement rule, require, as the Second and Seventh Circuits do, that collective

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[8] Latent ambiguities are of the type mentioned in the famous case of *Raffles* v. *Wichelhaus*, 2 H. & C. 906, 159 Eng. Rep. 375 (ex. 1864). There, a contract clearly called for shipment on a vessel named Peerless, but two ships departing from the same port shared that name. The hornbook rule derived from that case holds that any ambiguity may be resolved by reference to objective evidence—*beyond the self-serving testimony of one side*—that the contract could actually mean two things. Latent ambiguity is not an issue in the instant case, though, as respondents did not offer—and the Sixth Circuit did not identify—any objective evidence of an ambiguity that could support vesting.

bargaining agreements must contain language that can reasonably be construed as vesting benefits.

The clear statement rule and the affirmative-textual-indication rule are similar in that both require some basis in the actual language of the agreement that the parties intended vesting. Crucially, under either rule, mere durational silence is not enough to find benefits vested. That is because silence can neither guarantee a vested right nor create ambiguity in light of the background principles at work here. Nor can context be used to create an ambiguity that is then resolved by the same context.

Yard-Man has shown—in this very case—the confusion that can be sown by extra-textual considerations. A text-based rule will minimize that confusion and promote uniformity among the circuits concerning the appropriate level of "clarity" regarding vesting commitments. Then "the administration of collective bargaining contracts [will be able to be] accomplished under a uniform body of federal substantive law." *Smith*, 371 U.S. at 200.

At a minimum, then, there must be affirmative language indicating vesting in the collective bargaining agreement. There is no such language in the agreement here, so the Sixth Circuit's decision that the health-care benefits nonetheless were vested should be reversed.

IV. UNDER ANY MEANINGFUL STANDARD, THE SIXTH CIRCUIT'S JUDGMENT CANNOT STAND

While there has been isolated support for *Yard-Man*, see, e.g., *USW* v. *Connors Steel Co.*, 855 F.2d 1499, 1505 (11th Cir. 1988) (agreeing, in dicta, with the Sixth Circuit), the circuits almost uniformly disavow the Sixth Circuit's approach and instead insist on at least some textual indication of vesting. Because there is no such language in the collective bargaining agreement at issue here, petitioners would prevail under any of those other standards. As already demonstrated, *supra* 25-33, petitioners would prevail under the rules of construction applied by the Second, Third, and Seventh Circuits. And as demonstrated below, petitioners would prevail under any other standard that, in contrast to *Yard-Man*, does not presume vesting but instead relies on the plain language of the agreement to determine the scope and duration of the benefits conveyed within.

A. Durational Language In The Operative Agreements Indicates That The Health-Care Benefits Were To End With Those Agreements

The P&I agreements at issue here applied to union-represented employees by way of the local collective bargaining agreements and were specifically subject to durational clauses. For example, the local union and the employer entered into a collective bargaining agreement effective November 6, 1994

that expired November 6, 1997. JA 195. The collective bargaining agreement adopted the P&I agreement through Letter A, which provided that "for the duration of our Articles of Agreement which continue in effect until 12:01 a.m., November 6, 1994, and for the term of our next Agreement, the benefit plans currently applicable to employees you represent at the Point Pleasant Polyester Plant will be continued." *Id.* at 196-97.

The same durational limits are explicit in the P&I agreements. For example, the P&I agreement incorporated into the 1994 collective bargaining agreement described above introduced the health-care benefits program by explaining that "[e]ffective January 1, 1995 and for the duration of this Agreement thereafter, the Employer will provide" the health-care benefits described. *Id.* at 85. A Supplemental P&I agreement signed thereafter included the same language. *Id.* at 89, 100, 157. The Supplemental P&I further stated that "[t]he International Union, Local Unions, and the Employer agree that this Agreement terminates on April 19, 1997 and shall not be continued beyond that date." *Id.* at 97.[9]

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[9] Similar language can be found in the other collective bargaining agreements and P&Is at issue here. For example, the parties agreed to a collective bargaining agreement effective November 6, 1991 through November 6, 1994. JA 82. Through Letter A of that agreement, the parties agreed "that for the duration of this agreement all the terms and conditions of the Pension, Insurance and Service Award Agreement of May 15, 1991, as from time to time amended, between the Goodyear Tire

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This language plainly indicates that the health-care benefits were intended to last only as long as the agreement was in place. And having been set out in the collective bargaining agreement that adopted the P&I, and again at the very beginning of the P&I agreement itself, the language did not need to be repeated where the "full Company contribution" is mentioned. *Id.* at 134-35, 189.

B. When The Parties Intended Benefits To Vest, They Adopted Specific Language To Accomplish That Intention

The limited duration of the health-care benefits is made all the more clear when contrasted with

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and Rubber Company and the United Rubber, Cork, Linoleum and Plastic Workers of America, including the covering letters under the same date, will be applied to the employees covered by this Agreement[.]" *Id.* at 83-84. The P&I agreement adopted by the collective bargaining agreement also included durational limits, stating that "[e]ffective January 1, 1992 and for the duration of this Agreement thereafter, the Employer will provide" the medical benefits described. *Id.* at 33; see also *id.* at 11.

Likewise, the collective bargaining agreement effective November 6, 1997 through November 6, 2000 included Letter A, by which the "Company and the Union agree[d] that for the duration of our Articles of Agreement which continue in effect until 12:01 a.m., November 6, 2000, the benefit plans currently applicable to employees you [the union] represent at the Point Pleasant Polyester Plant will be continued[.]" *Id.* at 276. The P&I agreement, by its terms, was also limited to the duration of the agreement. See *id.* at 201 ("Effective May 9, 1997, and for the duration of this Agreement thereafter, the Employer will provide" certain medical benefits.).

express vesting language found elsewhere in the P&I agreements. For example, the 2000 P&I agreement references pension benefits that cannot be "reduced, suspended or discontinued." JA 376. And the section of the P&I that deals with "Top Heavy Vesting" references "an [e]mployee's nonforfeitable right" to a percentage of income conforming to a "vesting schedule." *Id.* at 376-77. Where the parties intended for a benefit to be vested, then, they knew how to draft language to express that intent. In contrast, there is no vesting language with respect to the health-care benefits at issue in this case. The agreement expressly limits those benefits to "the duration of this Agreement." *Id.* at 377.

Even if one thought the language describing a "full Company contribution" toward health care benefits (see, e.g., *id.* at 134-35, 189, 415) were ambiguous standing on its own—an argument undermined by the International union continuing to negotiate cap agreements even with the P&I language in place—considering the agreement as a whole would confirm that health-care benefits were never intended to outlive the agreement between the parties. Take, for example, the section of the P&I agreement that provides payment of a Special Medicare Benefit. *Id.* at 139, 421. It provides that the payment will continue as long as the Pensioner "continue[s] to be covered for benefits under this [contract]." If it is possible for the Pensioner to not continue to be covered, the benefits must not be vested. And it is a familiar rule of contract construction

that contracts must be read as a whole. See, e.g., *Instone Travel Tech. Marine & Offshore* v. *Int'l Shipping Partners, Inc.*, 334 F.3d 423, 428 (5th Cir. 2003) ("[T]he court should read all parts of the contract together to ascertain the agreement of the parties, ensuring that each provision of the contract is given effect and none are rendered meaningless." (citations omitted)).[10]

C. The Power Of The *Yard-Man* Presumption Is Apparent In Its Ability To Overcome Plain Contractual Language

As in other cases where it was applied, however, the *Yard-Man* presumption overcame the plain language of the agreement here. That much can be seen from the Sixth Circuit's decision in *Tackett I* reversing the district court's dismissal of respondents' claims as a matter of law and holding that the benefits were vested as a matter of law. Pet. App. 114. Indeed, the

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[10] The Sixth Circuit purports to follow ordinary contract principles (just as it disclaims applying any presumption of vesting) but, as Judge Sutton has explained, the reality in the Sixth Circuit is that "[u]nless a company can point to explicit language in the relevant agreement stating that 'retiree benefits' terminate at a particular date or do not vest, the benefits seem to vest as a matter of law." *Noe*, 520 F.3d at 568 (Sutton, J., concurring in part and dissenting in part). That the Sixth Circuit purports to reach that result under "ordinary contract principles," see, e.g., *Yard-Man*, 716 F.2d at 1481 n.2, is all the more reason this Court should make clear that those principles, properly understood and applied, do not support, much less require, the Sixth Circuit's approach to these cases.

decision overturned the district court's initial dismissal of all respondents' claims based on the undisputed evidence of cap agreements in place concerning the health-care benefits. *Id.* at 129, 131, 134.

In using *Yard-Man* to tie the district court's hands, the *Tackett I* panel held that "[a] court may find vested rights 'under a [collective bargaining agreement] even if the intent to vest has not been explicitly set out in the agreement.'" *Id.* at 58. In fact, the *Tackett II* panel later acknowledged that the court's earlier holding established "a controlling interpretation" of the collective bargaining agreement that was "dispositive of at least the vesting issue." *Id.* at 61. Thus, while the first panel paid lip service to not deciding the ultimate question, *id.* at 61-62, its summary of the agreement at issue was in fact "an unqualified declaration" that "'the parties intended health-care benefits to vest.'" *Id.* at 62. It was therefore unsurprising when the district court eventually made factual findings that aligned with its "conclusion that the Sixth Circuit answered the threshold vesting issue." *Id.* at 63.

But the collective bargaining agreement at issue was, at most, silent on that "threshold" issue—and as a result, the agreement's expiration provision controls and retiree health-care benefits do not extend beyond the agreement's terms. One may agree or disagree with the wisdom or policy of retiree benefits being subject to future negotiations. What cannot be debated, however, is that those individuals have the right to insist—before retirement, through their

union representatives—on the right to full vesting of benefits, and to weigh the inevitable trade-offs that must be made to obtain such an extraordinary benefit. Once *Yard-Man* was applied, however, the Sixth Circuit simply presumed that the parties intended vesting based on a-textual factors such as status and permissive bargaining.

Thus the trial that eventually took place had nothing to do with the vesting question that has divided the circuits. It simply determined "*what* vested"—not *whether* anything vested as an initial matter. Pet. App. 64 (emphasis in original). The district court was only "called upon to explain whether what vested include[d] specific benefits." *Ibid.* Once the error of *Tackett I* in applying *Yard-Man* is exposed, the correctness of the district court's original dismissal of respondents' claims as a matter of law becomes clear and unassailable.

Although the circuits may be "all over the lot" in their approaches to the vesting issue, petitioners in this case would have prevailed in any other circuit that has rejected *Yard-Man*. The First Circuit, for example, has declined to follow the Sixth Circuit because "the use of presumptions may interfere with the correct interpretation, under normal LMRA rules, of the understanding reached by the parties." *Senior* v. *NSTAR Elec. & Gas Corp.*, 449 F.3d 206, 218 (1st Cir. 2006). Similarly, the Fifth and Eighth Circuits also have rejected the notion of a *Yard-Man* presumption. *United Paperworkers Int'l Union* v. *Champion Int'l Corp.*, 908 F.2d 1252, 1261 n.12 (5th Cir. 1990)

("To the extent that *Yard-Man* held that there is, as a general proposition, an inference of an intent to vest retirement benefits (because they are 'status' benefits), we find merit in the Eighth Circuit's criticism in *Anderson* [v. *Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1516-20 (8th Cir. 1988),] of this aspect of *Yard-Man* and find no basis in logic or federal labor policy for such a broad inference.").

It may be that the Fifth Circuit would tolerate extrinsic evidence and inferences beyond what the Second or Seventh Circuit might allow, *ibid.*, but that is of no moment here because the Fifth Circuit nonetheless relies on the contract language *first* before roaming outside the contract in search of an intent to vest. *Int'l Ass'n of Machinists & Aerospace Workers, Woodworkers Div.* v. *Masonite Corp.*, 122 F.3d 228, 233 (5th Cir. 1997).

The key point is that whatever their differences, all of these circuits have uniformly rejected the Sixth Circuit's approach in which silence and context come together to both create an ambiguity and then resolve it. Here, the Sixth Circuit held that the context of retiree benefits created an "ambiguity" from silence; the court then resolved the "ambiguity" it had created by treating that context as extrinsic evidence which proves vesting. That *Yard-Man* double-whammy cannot be right.

But even if durational silence were properly treated as ambiguity, petitioners would still prevail here. That is because, before the Sixth Circuit put

its *Yard-Man* thumb on the scales, the district court initially ruled that extrinsic evidence—the cap agreements—required dismissal in petitioners' favor as a matter of law. Pet. App. 146-47.

This case thus confirms Judge Sutton's suspicion that in the Sixth Circuit, "[u]nless a company can point to explicit language in the relevant agreement stating that 'retiree benefits' terminate at a particular date or do not vest, the benefits seem to vest as a matter of law." *Noe*, 520 F.3d at 568 (Sutton, J., concurring in part and dissenting in part). That rule has no support in law or logic. Even if, then, silence in a collective bargaining agreement could be deemed an "ambiguity" justifying resort to extrinsic evidence (which it cannot), the evidence here (i.e., the cap agreements) makes plain that the benefits did not vest, respondents' claims should have been dismissed, and the Sixth Circuit's judgment should be reversed.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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RESPONDENT'S BRIEF

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M&G POLYMERS USA, LLC, *et al.*,
Petitioners,

v.

HOBERT FREEL TACKETT, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iv
STATEMENT OF FACTS	1
PROCEEDINGS BELOW	7
SUMMARY OF ARGUMENT	15
ARGUMENT	18
I. AS WITH ANY OTHER QUESTION OF CONTRACT INTERPRETATION, WHETHER A RETIREE HEALTH OBLIGATION CONTINUES AFTER THE COLLECTIVE BARGAINING AGREEMENT THAT CREATED THE OBLIGATION HAS EXPIRED DEPENDS ON THE PARTIES' ACTUAL INTENT	18
A. The Goal Of Contract Interpretation Is To Determine The Parties' Actual Intent	19
B. The Parties' Intent That A Retiree Health Benefit Obligation Will Continue In Force After A CBA Has Expired Need Not Be Expressed In Explicit Terms	21
C. ERISA Does Not Establish A Presumption That Rights To Retiree Health Benefits Continue Only As Long As The Agreement That Was In Effect When An Employee Retired	35

TABLE OF CONTENTS—Continued

Page

II. TRADITIONAL RULES OF CONTRACT INTERPRETATION SUPPORT THE JUDGMENT BELOW 38

A. Traditional Rules Of Contract Interpretation Require Only That The Parties' Language Be "Reasonably Susceptible" To The Asserted Meaning When Read In The Context Of All Related Agreements And The Parties' Course Of Performance 39

B. Under Traditional Rules, The Agreements Were Reasonably Interpreted To Provide That The Retiree Health Benefits Were Promised For Life 40

1. The Language Of The Retiree Health Promise Is Reasonably Susceptible To The Lower Courts' Interpretation 40

2. The Employers' Course Of Performance Is Not Consistent With Any Other Interpretation 42

3. Other Provisions In The P&I Agreements Confirm This Intent 45

C. The Duration Clauses Did Not Terminate Retiree Health Benefits 46

TABLE OF CONTENTS—Continued

Page

1. M&G's Argument From The Duration Clauses Is Not Properly Before The Court 47

2. If The Court Considers M&G's New Argument, It Should Conclude That The Duration Clauses Do Not Limit Retiree Health Benefits..... 49

D. This Agreement Is Not "Silent" On The Duration Of Retiree Health Benefits, And The Sixth Circuit's Judgment Does Not Depend On Any Presumption Based On Such "Silence" 52

CONCLUSION 56

TABLE OF AUTHORITIES

CASES:	Page
Alabama v. North Carolina, 560 U.S. 330 (2010)	39
Allied Chem. & Alkali Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971)	30
Bender v. Newell Window Furnishings, Inc., 681 F.3d 253 (6th Cir. 2012)	54
Bidlack v. Wheelabrator Corp., 993 F.2d 603 (7th Cir. 1993)	27, 29, 31, 33
Chesapeake & Ohio Canal Co. v. Hill, 82 U.S. 94 (1872)	19
City of Springfield v. Kibbe, 480 U.S. 257 (1987)	48
Consol. Rail Corp. v. Ry. Labor Executives' Ass'n, 491 U.S. 299 (1989)	22
Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014)	35
Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)	37
IBEW Local 1395 v. NLRB, 797 F.2d 1027 (D.C. Cir. 1986)	21
Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe R.R. Co., 520 U.S. 510 (1977)	36
International Union, UAW v. Skinner Engine Co., 188 F.3d 130 (3d Cir. 1999)	28

TABLE OF AUTHORITIES—Continued

Page

International Union, UAW v. Yard-Man, 716 F.2d 1476 (6th Cir. 1983) 13, 54, 55

Int'l Union, UAW v. ZF Boge Elastmetall LLC, 649 F.3d 641 (7th Cir. 2011) 27

John Wiley & Sons v. Livingston, 376 U.S. 543 (1964) 20, 26

Keffer v. H.K. Porter Co., 872 F.2d 60 (4th Cir. 1989)..... 33

Kifafi v. Hilton Hotels Ret. Plan, 701 F.3d 718 (D.C. Cir. 2012)..... 36

Lewis v. Benedict Coal Corp., 361 U.S. 459 (1960) 31, 32

Litton Financial Printing Division v. NLRB, 501 U.S. 190 (1991) 15, 21-26

Mastrobuono v. Shearson Lehman Hutton, Inc., 514 U.S. 52 (1995)..... 39

Medimmune, Inc. v. Genentech, Inc., 549 U.S. 118 (2007) 48

NLRB v American Nat'l Ins. Co., 343 U.S. 395 (1952) 20, 22

NLRB v. C&C Plywood Corp., 385 U.S. 421 (1967) 20

NLRB v. Wooster Div. of Borg-Warner Corp., 356 U.S. 342 (1958) 30

TABLE OF AUTHORITIES—Continued

Page

Nolde Brothers, Inc. v. Bakery Workers, 430 U.S. 243 (1977) 23, 24, 41

Quesenberry v. Volvo Trucks N. Am. Retiree Health Benefit Plan, 651 F.3d 437 (4th Cir. 2011) 34

Rossetto v. Pabst Brewing Co., 217 F.3d 539 (7th Cir. 2000) 53

Steelworkers v. Am. Mfg., 363 U.S. 564 (1960) 20

Transp.-Commc'n Emps. Union v. Union Pac. R.R. Co., 385 U.S. 157 (1966) 39

Trull v. Dayco Products, LLC, 329 F. Supp. 2d 658 (W.D.N.C. 2004), *aff'd*, 178 F. App'x 247 (4th Cir. 2006) 32

William B. Tanner Co. v. Sparta-Tomah Broad. Co., 716 F.2d 1155 (7th Cir. 1983) 27

Yee v. City of Escondido, 503 U.S. 519 (1992) 48

STATUTES, RULES AND LEGISLATIVE MATERIAL

26 U.S.C. § 401(a)(10)(B)(ii) 51

29 U.S.C. § 185 7

29 U.S.C. § 1053 36

29 U.S.C. § 1053(a) 51

29 U.S.C. § 1054 36

29 U.S.C. § 1132(a) 7

29 U.S.C. § 1144(d) 37

H. Rep. No. 807, *reprinted in* 1974 U.S.C.C.A.N. 4670 (1973) 36

S. Rep. No. 93-383, *reprinted in* 1974 U.S.C.C.A.N. 4889 (1973) 36

S. Ct. Rule 14.1(a) 47

OTHER AUTHORITIES

3 A. Corbin, *Corbin on Contracts* § 553 (1960) 27

A. Farnsworth, *Contracts* § 3.1 (1982) 26

A. Farnsworth, *Contracts* § 3.3 (1982) 26

A. Farnsworth, *Contracts* § 7.10 (3d ed. 1999) 27

Financial Accounting Standards Board, Statement of Financial Accounting Standards No. 106 (Dec. 1990), *available at* www.fasb.org/summary/stsum106.shtml (last accessed 9/11/14) 31

Restatement (Second) of Contracts § 201, cmt. c (1981) 20

Restatement (Second) of Contracts § 215, cmt. b (1981) 39

Restatement (Second) of Contracts § 202(2) (1981) 34, 39

Restatement (Second) of Contracts § 202(5) (1981) 39

STATEMENT OF FACTS

The facility where this case arose, called Apple Grove, produces polyester resin in Point Pleasant, West Virginia.

For more than 30 years, up to November 1992, Goodyear Tire & Rubber Company owned and operated Apple Grove. During that time Local Union 644 of the United Rubber Workers ("URW") (which later merged with the United Steelworkers)[1] represented Apple Grove's active employees. PA32.[2] Goodyear and the URW negotiated collective bargaining agreements ("CBAs") every few years that provided terms and conditions of employment—including employee benefits—for the active employees. Those CBAs included both "Basic Agreements" and Pension, Insurance and Service Award Agreements ("P&I

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[1] The full name of the United Steelworkers is United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO/CLC.

[2] Citation notations in this brief are as follows. "JA__" refers to the Joint Appendix. "PA__" refers to the Petition Appendix. "R__" refers to docket entries in the district court record (S.D. Ohio 2:07-cv-00126-GLF-MLK). "JX__" and "PX__" refer to joint exhibits and plaintiffs' exhibits, respectively, admitted at trial in this matter; a list of those exhibits is found at R214.

"Pet. Br." refers to Petitioners' merits brief. As for briefs by *amici*, "Whirlpool Br." refers to the brief of Whirlpool Corporation; "NAM Br." refers to the brief of National Association of Manufacturers; "ERIC Br" refers to the brief of the ERISA Industry Committee; and "CLLE Br." refers to the brief of the Council on Labor Law Equality and the Society for Human Resource Management.

Agreements"). There was master bargaining between Goodyear and the URW at a number of other facilities, not including Apple Grove, PA31-32, followed by negotiations for Apple Grove in which the parties adopted certain results of master bargaining on the basis of "me, too—with exceptions." PA66.

In 1992, Shell Chemical Company purchased Apple Grove and assumed Goodyear's contractual obligations to the then-active employees. PA31-33. Shell and Local 644 bargained their first CBA in 1994 and agreed to adopt the 1994 Goodyear P&I Agreement, with exceptions, for purposes of continuity. JA457-58, 461. In 1997, Shell and Local 644 created their own P&I Agreement, patterned closely after the 1994 version. JA198-274.

In 2000, Shell sold Apple Grove to Mossi & Ghisolfi Overseas SA, a Luxembourg company, JA302; PA34, and its subsidiary, M&G Polymers, USA ("M&G"). M&G agreed to assume the existing P&I Agreement as well as Shell's liability for future pensions and retiree health benefits to employees who had retired from Apple Grove under Shell's ownership. JA302, 309-10. The parties credited the full actuarial value of that liability toward M&G's purchase price. JA311-13. That valuation—and, thus, the net purchase price—was based on assumptions described in Exhibit 2E2(c) to a Human Resources Agreement relating to the sale. As to the health benefits, those assumptions included "Coverage" described as "Lifetime for Retirees and Spouses" and "Retiree Contributions" described as "None." JA323, 329-30.

After bargaining in 2000, M&G and Local 644 prepared their own P&I Agreement. JA333. The 2000 P&I agreement was still in effect when this case was tried.

The P&I Agreements. Each P&I Agreement describe the pension plan, *e.g.*, JA335, insurance programs, *e.g.*, JA338-54, medical benefits, *e.g.*, JA355, and various other benefits for active employees, *e.g.*, JA356-57. The articles setting out benefits for active employees also contained language providing benefits for employees retiring during the term of each agreement.

The retiree health benefit rule in effect for most of the period relevant to this case made the following promise to long-service retirees "receiving a monthly pension":

> Employees who retire on or after January 1, 1996 and who are eligible for and *receiving a monthly pension* under the 1993 Pension Plan . . . whose full years of attained age and full years of attained continuous service . . . at the time of retirement equals 95 or more points *will receive a full Company contribution* towards the cost of the benefits described in this Exhibit B-1.

JA415 (emphasis supplied). A retiree with fewer than 95 age-and-service points was entitled to an employer contribution reduced in proportion to the difference between the retiree's actual point total and 95; the retiree was required to pay the difference. JA415.[3]

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[3] In earlier agreements, the proportionality was less precise. These agreements promised that a retiring employee with at least 10 years continuous service "shall receive the benefits" described in the applicable exhibit, while a retiring employee with less than 10 years continuous service could maintain the benefits by paying for them at the group rate. For employees hired after 1988, the rules required 20 years of continuous service for the full benefit, and those who had between 10 and 20 years would have to pay half of the cost. *E.g.*, JA75-76.

"Exhibit B-1" (or a similar denomination) in each P&I Agreement included detailed descriptions of the particular health benefits that would be provided and the amounts that participants would have to pay as copayments or deductibles. JA377-421.

The P&I Agreements also provided health benefits for spouses of retirees who died while receiving a pension. Such a surviving spouse "shall be entitled to continue to receive the benefits of this Exhibit B-1 *until death or remarriage* under the exact same conditions and amounts that such surviving spouse was entitled to such benefits as a dependent immediately prior to the death of such former Employee." JA417 (emphasis supplied).

In 1994, the parties agreed that an optional "Medical Necessity Program" would be terminated for active employees after 1994, but anyone retiring before January 1, 1995, could elect to keep that program after retirement. JA193. The effective date of that change was later moved to August 1, 1997, with the same understanding that employees retiring before that date could keep the Medical Necessity Program after retirement even though it was no longer provided for active employees. JA272-73. At the time of trial, that coverage was still being provided to the retirees who had elected it. JA497-98.

The 1997 P&I Agreement refers only to retiree health benefits for employees retiring on or after January 1, 1996 and is silent as to health benefits for those who had retired before that date. JA263-65. Nonetheless, Shell—which was the employer in 1997—continued to provide the benefits described in the earlier P&I Agreements. M&G, after purchasing Apple Grove

and assuming Shell's liability, continued to provide retiree health benefits to all of those retirees as well as those who retired afterward. *See* PX255 at 13-16, R189 at 21.

Each P&I Agreement had a duration clause for the agreement as a whole, *e.g.*, JA359-61, and separate duration clauses for each article within it. Each article—including that comprising the pension plan—states that its benefits will be provided for "Employees" "for the duration of this Agreement." *E.g.*, JA335, 338. In the case of health benefits, the language immediately preceding the duration clause refers to the benefits that are the subject of the clause as "benefits for employees and their dependents." JA355, 377.[4]

The "Cap Letters." In 1991 master bargaining with URW locals (not including Local 644), Goodyear proposed and obtained a side letter called "Letter G" that set caps on the amounts Goodyear would be required to pay for retiree health benefits beginning *in 1997*—well beyond the term of the 1991 Agreement. That letter stated:

> The Company shall provide health care benefits under the Medical Necessity Benefits Program, Exhibit B-1, the Major Medical Benefits Program, Exhibit B-2, the Comprehensive Medical Benefits Program, Exhibit C-1, . . . of the Pension, Insurance and Service Award Agreement dated May 15, 1991, to the extent that such benefits shall be subject to the following limitations:

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[4] "Employee" is defined as an employee who is in the bargaining unit during the term of the Agreement. *E.g.*, JA334.

1. The average annual Company contributions to be paid for all health care benefits per retired employee (including their surviving spouses) who retires on or after May 1, 1991, shall not exceed $10,500 for retirees (including surviving spouses) under age 65 and $4,200 for retirees (including surviving spouses) over age 65.

PA4-5; JX14, R185 at 133-34. The letter provided that retirees would pay any excess over those caps, then added: "no retired employee or surviving spouse shall be obligated to contribute for such excess health care cost until July 1, 1997." JX14.

Goodyear and the unions involved in its master bargaining updated the cap letter in each of Goodyear's subsequent agreements, increasing the amount that Goodyear was required to pay and moving the July 1, 1997 date to a later year. PA94 n.1; *e.g.*, JA435-37.

In the 2000 bargaining, M&G's chief negotiator asserted M&G's belief that the Goodyear cap letters had never been part of the Shell agreement that it had assumed, and that the Goodyear cap letter "does not apply to M&G (or Shell previously)." JA331. In the next round of bargaining, however, M&G demanded such a cap letter for the Apple Grove agreement. Ultimately, despite the union's opposition, a "Letter of Understanding 2003-6" was signed August 9, 2005, stating that beginning January 1, 2006, M&G's cost would be capped at the amount stated in Goodyear's 2001 cap letter. JA438-41. Effective January 1, 2007, M&G took the position that Letter 2003-6 applied to current retirees as well as future retirees. M&G changed the retiree benefit design to conform to the

benefits for active employees and began to charge costs above the cap to all Apple Grove retirees. The amounts that M&G required them to pay were so large that 88 out of 238 lost their coverage in the first year. R189 at 217.

The union and retirees sued, asserting under Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185, that M&G had violated the applicable CBAs by reducing vested benefits, along with claims under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a). A class of retiree plaintiffs was certified. PA26-27.

PROCEEDINGS BELOW

M&G initially moved to dismiss. It did not argue that "duration of the Agreement" clauses meant that retiree health benefit rights had terminated with the respective P&I Agreements, but relied entirely on an argument that the Goodyear cap letters had been part of the Apple Grove agreements when all of the plaintiffs retired and that those letters continued in effect. Pointing to the provision in Goodyear cap letters that retirees would have to pay any amounts exceeding the employer's cost cap, M&G argued that those letters, as a matter of law, "defeat[ ] any claim that the Retiree Plaintiffs had a vested right to lifetime contribution-free benefits." R36 at 6; *see also* R19 at 15. The retirees responded that the parties at Apple Grove had never adopted the Goodyear cap letters, and that the Letter 2003-6 covered only people retiring after it was adopted (and that even if wrongly interpreted to apply to prior retirees, it could not take away rights that had already vested before it was added to the contract). R34 at 8; R35 at 19-20.

The 2007 Dismissal. The district court granted the motion to dismiss, holding that, as a matter of subject-matter jurisdiction under Section 301 of the LMRA, the court needed to resolve the factual dispute whether the Apple Grove agreements included any cap letters before Letter 2003-6, and finding that the agreements did include those letters. PA125-27, 131-32. In the alternative, the district court dismissed the Complaint under Rule 12(b)(6), on the ground that the "95 point" language in the P&I Agreements, in stating that retirees with 95 points were entitled to "a full Company contribution *towards* the cost of the benefits," did not mean that the employer would pay the full cost. PA142-43 (emphasis supplied).

Tackett I. Retirees appealed. M&G defended the appeal by relying on the district court's interpretation of the "full Company contribution" language and on the Goodyear cap letters. M&G did not make any alternative argument that the retiree health benefit promises expired when each agreement terminated. *See* Appellees' briefs in 07-4515 (Dkt. #39) and 07-4516 (Dkt. #41).

The court of appeals reversed. It first held that the district court erred in weighing disputed evidence to hold that Goodyear cap letters were part of the Apple Grove CBAs before 2005, because subject-matter jurisdiction under Section 301 requires only an allegation that a CBA was violated; if the parties disagree about the contents of that agreement, that disagreement cannot be resolved on a motion to dismiss. PA96-104. The court of appeals then held that the "full Company contribution" paragraph could be plausibly interpreted as an agreement that retiree health bene-

fits "vest," *i.e.*, survive the expiration of successive agreements. PA111-13. In preface, in conclusion, and throughout its discussion of the Section 301 claim, the court consistently described its ruling as a conclusion that plaintiffs had plausibly alleged an agreement to vest. PA90, 104 n.5, 113, 119. When it turned to the parallel ERISA claim, the court said that the "determination above that the parties intended health-care benefits to vest carries over to the ERISA § 502(a)(1)(B) claim," but then restated its holding squarely in the terms of Rule 12(b)(6): "Plaintiffs have therefore presented a plausible claim under ERISA § 502(a)(1)(B)." PA114.

Proceedings on Remand. On remand the parties conducted discovery and M&G subsequently moved for summary judgment, again asserting that Goodyear cap letters were in effect at Apple Grove when all of the class members retired, and that "a full Company contribution *towards* the cost of the benefits" required the employer to pay only up to the caps. M&G again did *not* argue that "duration of the agreement" clauses meant that the retiree health benefit promises expired with successive contracts. R135 at 1; R151; R156 at 2. Rather to the contrary, in supporting its argument that the Goodyear cap letters had never expired, M&G argued that general duration language "does not limit retiree benefits, absent specific durational language referring to retiree benefits themselves." R151 at 18. M&G did not argue that the P&I Agreements contained any such "specific durational language." *Id.*

The district court denied M&G's motion. R163. The court addressed the court of appeals' reference,

in discussing the ERISA claim, to "[t]he determination above that the parties intended health-care benefits to vest," and held that the court of appeals "has answered the threshold vesting issue." *Id.* 14. In the alternative, the district court held that if the vesting question was still open, it would hold that the "full Company contribution" paragraph established an intent to create vested rights to some level of benefits: "The question is not *did* vesting occur, but *what* vested." *Id.* 15. The district court then held that there was a genuine dispute of material fact as to "which agreements do in fact apply to the Apple Grove plant." *Id.* 21-22.

The evidence at trial focused on whether the Goodyear cap letters were part of the agreements at Apple Grove. M&G introduced no evidence that the parties intended retiree health benefits to expire with each agreement. Both sides presented testimony about Apple Grove bargaining sessions. M&G's witnesses testified that all of the Goodyear cap letters were adopted at Apple Grove; Retirees' witnesses testified that they were not.

Following trial, the district court resolved that factual dispute against M&G in detailed findings of fact.[5] The court found:

> The pre-August [9], 2005 side agreements to the master agreements [*i.e.*, cap letters] do not apply

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[5] The findings of fact on liability are in the district court record at R177, but are restated in the district court's subsequent opinion on entry of a permanent injunction, which is in the Petition Appendix. We cite to the findings in the Petition Appendix instead of the docket, for the convenience of the Court.

> to Apple Grove. Rather, the intent and effect of the applicable operative documents governing Subclasses One through Four [all who retired before August 9, 2005] present a lifetime benefits scheme for qualifying retirees and beneficiaries without the cost-sharing Defendants wrongly imposed. The cap letters were not part of these agreements, and even if they were, they were wholly abandoned.

PA65-66. The court explicitly based this finding on witnesses' credibility. The court explained that the testimony presented by M&G conflicted with documentary evidence, PA67-68, conflicted with M&G's actions and other communications, PA72, "lacked veracity," PA74, and was "simply not credible," PA72. The court found the testimony of the retirees and the union "more credible," PA68, and "notably more compelling," PA65. The court summarized its findings from the evidence as follows:

> Ultimately, this litigation presents a scenario in which a company faced with ballooning benefits costs uncovered a longshot means by which it could attempt to retroactively rewrite agreements to reduce costs . . . .

PA74.

> Defendants developed the contribution scheme as a self-serving response to economic realities and in contravention of the negotiations conducted and applicable agreement reached.

PA75.

As to Letter 2003-6, the district court held that it applied only to Subclass 5, whose members retired

after the union agreed to the letter. PA70-71. The district court thus concluded that those who retired before August 9, 2005 "are entitled for the company to cover the full cost of the health benefits, without these plaintiffs being required to pay premium contributions." PA75.

The district court then addressed whether the agreements allowed M&G to modify the plan design, or instead gave retirees the right to the same coverage they had when they retired. PA77. On the evidence, the court concluded that "the plan was susceptible to reasonable changes" that did "not disturb the essential nature of the benefit provided." PA79, 82-86. The court therefore entered a permanent injunction requiring reinstatement of pre-August 9, 2005 retirees into the benefit plan and enjoining M&G from charging premiums. PA76, 86-87. Everyone except the subclass of post-August 9, 2005 retirees appealed.

Tackett II. On appeal, M&G again did not rely on "duration of the agreement" clauses and did not argue that retiree health benefit promises expired at the end of each agreement. M&G's only argument on the language of the agreements (apart from the cap letters) was that in the 95-point paragraph the phrase "a full Company contribution towards the cost of the benefits" did not create a vested right to lifetime benefits without contributions, especially when combined with cap letters. *See* Appellants' briefs in 12-3329, First Brief (Dkt. #38) at 59; Third Brief (Dkt. #41) at 36-39, 50-56.

The court of appeals first addressed M&G's argument that Goodyear cap letters were part of the labor agreements and found the question to be one of fact,

reviewable only for clear error. PA14. After considering the evidence, the appellate court concluded that the district court had not clearly erred.

The Sixth Circuit framed the remaining issue, as had M&G, as "whether the collectively bargained agreements between Plaintiffs and Defendants vested in Plaintiffs a right to lifetime no-contribution health care benefits." PA10. Citing *International Union, UAW v. Yard-Man*, 716 F.2d 1476 (6th Cir. 1983), the court held that the question hinged on the parties' intent when they signed the applicable agreements. PA10-11 (internal citations and quotations omitted).

The court of appeals corrected the district court's misimpression that *Tackett I* had finally determined the question of vesting.[6] The court pointed out that it had decided only a Rule 12(b)(6) motion and had "acknowledged the possibility that the district court might determine on remand that Plaintiffs did not have vested benefits." PA13. "For these reasons, *Tackett I* did not conclusively determine that Plaintiffs' retirement benefits had vested." PA13. But, because the district court had "performed its own analysis of the facts," and given that M&G's primary argument against vesting—the applicability of the cap letters—had been discredited, the court affirmed the district court's conclusion that the other language in the agreement, and the other evidence it considered, supported vesting. *Id.*

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[6] Despite this clarification by the court of appeals, Petitioners' Brief twice quotes the district court's erroneous reading of *Tackett I*, while claiming it was quoting from the Sixth Circuit itself. Pet. Br. 11, 39.

The court of appeals reiterated its conclusion that the district court did not err in finding cap letters inapplicable and, "[g]iven that," the district court did not err in interpreting the agreements to vest health benefits. PA14-18. And the court of appeals held that the district court's interpretation of the pre-2005 agreements, on the trial record, was not clearly erroneous. "Interpretation of a CBA is a matter of law only when the parties rely wholly on the terms of the CBA and do not present any extrinsic evidence of intent." PA18. In this case, after both sides introduced extrinsic evidence at trial, the determination of intent was a mixed question of law and fact. PA18.

Turning specifically to the 95-point provision that had been the focus of *Tackett I*, the court said that it had interpreted that language

> standing alone, as indicating intent to vest and this interpretation bound the district court, while leaving it free to make its own conclusion about the ultimate question of vesting based on other portions of the document, extrinsic evidence or both. . . . The qualifying language in *Tackett I* implied that the CBA language, though indicating intent to vest, contained enough ambiguity to permit examination of such additional evidence.

PA19-20. In the absence of extrinsic evidence that the parties did not intend to give eligible retirees continuing rights, and given the finding that the cap letters did not apply, "the district court did not clearly err in finding that pre-August 9, 2005 retirees had a vested right to receive contribution-free health care benefits." PA21-22.

Finally, the court of appeals affirmed the district court's decision that it was reasonable for M&G to modify the benefits of pre-2007 retirees to conform to the health plan covering active employees. PA22-23.

SUMMARY OF ARGUMENT

M&G has framed the question presented as a choice among what it portrays as three special rules that courts of appeals have employed to determine whether a CBA requires an employer to continue providing health benefits to its retirees beyond the expiration date of that particular agreement. This brief will show that no special rules are needed—or appropriate—for that task, but that the courts should employ traditional rules of contract interpretation, to the extent consistent with national labor policy, to resolve this question, just as they employ them to resolve other questions that arise under CBAs. And, applying those rules, the Court should affirm the judgment below.

I. The first principle of contract interpretation is that a court's goal is to determine what the contracting parties actually intended. That principle is especially important in construing CBAs because national labor policy seeks to promote industrial peace by encouraging employers and unions to reach voluntary agreements that best serve their particular needs, and to enforce those agreements without substituting any ideas of what their substantive agreements should be.

No special rule applies when the question is whether the parties intended that a specific provision of their agreement will continue to bind one (or both) of the parties after the contract's termination date. In *Litton Financial Printing Division v. NLRB*, 501

U.S. 190 (1991), the Court held that this question is to be determined in accordance with traditional principles of contract interpretation. M&G's argument that *Litton* required that such an intent be expressed in "explicit terms" is based on a patent misreading of this Court's opinion and is inconsistent with its actual holding.

The other authorities on which M&G relies similarly fail to support the posited requirement of explicit terms to create a continuing health-benefit obligation to retirees. Neither this Court's other decisions nor any traditional principles of contract interpretation require a heightened degree of specificity to support such an obligation. And the decision that Congress made in 1974 not to include in ERISA a mandate that health benefits be vested like pension benefits cannot support an implied limitation on voluntary agreements to provide such benefits.

II. Traditional rules of interpretation support the judgment below. The language of the P&I Agreements, interpreted as a whole and in light of the employers' course of performance, was reasonably susceptible to the interpretation that M&G must continue providing health benefits to employees who retired before August 9, 2005, without retiree contributions.

The specific provisions for retiree health benefits promised that employees who are "eligible for and *receiving* a monthly pension" "will receive" the full company contribution towards the cost of health benefits, and "shall have his medical benefits after retirement provided under Exhibit B." This language indicates that the retiree will receive health benefits as long as he is "receiving a monthly pension," not just for the

very short period between the date of retirement and the expiration of the CBA in effect on that date. That interpretation is reinforced by the promise that after a retiree dies, his surviving spouse will "continue to receive the benefits . . . until death or remarriage," and also by the Agreements' use of open-ended phrases similar to "will receive" or "shall have . . . benefits after retirement provided" in other contexts to describe what is clearly a lifetime promise.

Throughout the relevant time period the employers acted in ways that are consistent only with an understanding that each retiree's rights to health benefits were established by the agreement that was in effect at retirement, and were not affected by subsequent expiration of those agreements. To highlight only one example here, Shell and M&G continued to provide benefits to those who retired before January 1, 1996, although subsequent P&I Agreements were entirely silent about their rights to benefits, and Shell transferred the liability for providing those benefits to M&G as part of the sale of Apple Grove, crediting M&G's purchase price with the value of that liability, calculated on the understanding that the benefits were for life. *Supra* at 2.

M&G's new-found argument that the duration clauses expressly limited the duration of retirees' health benefits is not properly before the Court. It is not fairly included in the question presented; it contradicts M&G's argument in the Petition that the agreements were "silent on the duration of the health-care benefits"; and M&G's failure to raise it below meant that Retirees had no notice of a need to present evidence on that question and the courts below had no

reason to consider it. But even if the Court were to consider the new argument, there is no merit in it. The same kind of duration clause language applies to the pension article in the P&I Agreements. That language therefore cannot be interpreted, as M&G would have it, as an unconditional termination of all benefit rights created in those agreements. And the parties' use of words like "vesting" and "nonforfeitable" in the article describing pension rights is readily explained by ERISA's statutory requirements for pension plans, and supports no negative inference as to the absence of the same words in the health benefit article.

Thus, the judgment below rests on traditional rules of interpretation—not on any presumption in favor of vesting. In this case, as in *Yard-Man*, the Sixth Circuit has not proceeded on the basis of any such presumption. The judgment below should be affirmed.

ARGUMENT

I. AS WITH ANY OTHER QUESTION OF CONTRACT INTERPRETATION, WHETHER A RETIREE HEALTH OBLIGATION CONTINUES AFTER THE COLLECTIVE BARGAINING AGREEMENT THAT CREATED THE OBLIGATION HAS EXPIRED DEPENDS ON THE PARTIES' ACTUAL INTENT

As framed by M&G, the question presented asks this Court to adopt one of three court of appeals approaches for deciding whether a CBA provides health benefits for retirees that are intended to survive the agreement's termination. Pet. Br. *i*. Those three approaches are (A) to apply a presumption, which M&G incorrectly attributes to the Sixth Circuit, "that silence concerning the duration of retiree health-care benefits

means the parties intended those benefits to vest (and therefore continue indefinitely)," *id.*; (B) to apply the Third Circuit's opposite presumption, refusing to find any such intent absent "a clear statement that health-care benefits are intended to survive the termination of the collective bargaining agreement," *id.*; or (C) to "require at least some language in the agreement that can reasonably support an interpretation that health-care benefits should continue indefinitely," the approach M&G attributes to the Second and Seventh Circuits, *id.*, and on which M&G places a restrictive gloss.

The answer to the question presented, thus framed as whether the courts should follow alternative A, B, or C, is "No." There is a fourth alternative, which has the virtues of being both simpler and legally correct: to interpret promises of this character through the traditional principles of contract interpretation, just as the courts interpret all other promises in CBAs.

We will show in Part I that this Court's traditional principles for the interpretation of contracts generally, and CBAs in particular, require this simpler approach. Then we will show in Part II, applying those interpretive rules to the Apple Grove agreements directly rather than through the distorting lens of some special rule, that the judgment below should be affirmed.

A. The Goal of Contract Interpretation Is To Determine The Parties' Actual Intent

The "fundamental rule in the construction of all agreements" is to "ascertain the substantial intent of the parties." *Chesapeake & Ohio Canal Co. v. Hill*, 82 U.S. 94, 100 (1872); *see also* Restatement

(Second) of Contracts ("Restatement") § 201, cmt. c (1981); Pet. Br. 16 ("the parties' intent . . . is the touchstone of the analysis").

Interpreting and enforcing agreements in accordance with the parties' intent is particularly important with respect to a CBA, which is "not an ordinary contract," *John Wiley & Sons v. Livingston*, 376 U.S. 543, 550 (1964), but one that must be interpreted and enforced so as to further the national policy "to promote industrial peace by encouraging the making of voluntary agreements governing relations between unions and employers" without dictating the "substantive terms" of those agreements. *NLRB v American Nat'l Ins. Co.*, 343 U.S. 395, 401-02 (1952). When parties have resolved a labor dispute through such a voluntary agreement, labor peace between them is promoted by giving that agreement the meaning they intended, not a meaning discerned by reference to "abstract definitions unrelated to the context in which the parties bargained and the basic regulatory scheme underlying the context." *NLRB v. C&C Plywood Corp.*, 385 U.S. 421, 430 (1967). *See also Steelworkers v. Am. Mfg.*, 363 U.S. 564, 567 (1960) ("[S]pecial heed should be given to the context in which collective bargaining agreements are negotiated and the purpose they are intended to serve").

As Judge Silberman has succinctly put it, the cardinal principle in construing CBA provisions is to "give the parties' intent controlling weight . . .whether that intent is established by the language of [a particular] clause itself, by inferences drawn from the contract as a whole, or by extrinsic evidence." *IBEW*

Local 1395 v. NLRB, 797 F.2d 1027, 1036 (D.C. Cir. 1986) (internal quotation marks omitted).

B. The Parties' Intent That A Retiree Health Benefit Obligation Will Continue In Force After A CBA Has Expired Need Not Be Expressed In Explicit Terms

1. The parties' intent determines whether a retiree health obligation continues after the termination of the CBA, just as it determines any other question of contract interpretation.

Parties to a CBA, like parties to any contract, are free to agree, and often do agree, to promises that will continue in force after the contract has expired by its terms. Thus, in *Litton Financial Printing Division v NLRB*, 501 U.S. 190 (1991), the Court recognized that the proposition that "an expired contract has by its own terms released all its parties from their respective contractual obligations" does *not* apply to "obligations already fixed under the contract but as yet unsatisfied." *Id.* at 206. And the *Litton* Court also recognized that a CBA provision states a continuing obligation "where an action taken after expiration infringes a right that accrued or vested under the agreement, or where, under normal principles of contract interpretation, the disputed contractual right survives expiration of the remainder of the agreement." *Id.*

As was stated with respect to the NLRB in *IBEW Local 1395*, under those normal principles of contract interpretation, in construing CBAs courts and agencies "may not, in the guise of enforcing the 'plain meaning' of contractual language, erect an inflexible presumption on an issue turning on the parties' *actual*

intent." 797 F.2d at 1036 (emphasis in original). Indeed, to subject rights claimed pursuant to a CBA, whether predicated on "express or implied terms," *Consol. Rail Corp. v. Ry. Labor Executives' Ass'n*, 491 U.S. 299, 308 (1989), to a "selectively heightened level of scrutiny ([such as] a 'clear and patent' . . . standard) . . . would, in effect, be impermissibly to 'pass upon the desirability of the substantive terms of labor agreements,' *American National Insurance Co.*, 343 U.S. at 408-09, by affording [those] terms a less favored status." *Consolidated Rail Corp.*, 491 U.S. at 309.

2. There consequently is no room for M&G's proposed rule for construing CBA retiree health benefit provisions, under which "[t]he vesting of health-care benefits must be clear and express in the language of the agreement." Pet. Br. 25. M&G presents this as a corollary to what it portrays as this Court's "holding [in *Litton*] that 'contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement,' unless the 'collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration.'" *Id.* 17 (purporting to quote *Litton*, 501 U.S. at 207-08). But *Litton* in fact holds to the contrary: Whether a party's contractual obligation continues in force after the contract's expiration depends on the parties' actual intent, however expressed, determined by the traditional principles of contract interpretation.

a. The question presented in *Litton* was whether an employer was required to arbitrate a grievance asserting that, after the CBA had expired, the employer selected employees for layoff in a manner that vio-

lated seniority rights created by that agreement. The Court began by recognizing that "constraints upon the employer after the expiration date of a collective-bargaining agreement . . . may arise . . . from the express *or implied* terms of the expired agreement." *Litton*, 501 U.S. at 203 (emphasis supplied). The Court cited the example of *Nolde Brothers, Inc. v. Bakery Workers*, 430 U.S. 243 (1977), where the Court held that an employer was required to arbitrate a claim for severance pay arising from a plant closing after the CBA was terminated, even though the agreement did not explicitly provide that either the severance pay obligation or the obligation to arbitrate survived expiration of the agreement.

In *Litton*, as in *Nolde*, the CBA did not explicitly provide that the obligation to arbitrate would continue after the agreement expired; and the agreement contained a duration clause that, as the Court described it, required observance of the contractual terms "until the date of expiration and no longer." 501 U.S. at 205. Nevertheless, in view of the purpose of an arbitration clause to resolve all disputes that arise under the contractual relationship, the *Litton* Court held that "if a dispute arises under the contract here in question, it is subject to arbitration even in the post-contract period." *Id.*

The Court thus found it necessary to determine whether the dispute over the employer's post-expiration layoffs arose under the contract, *i.e.*, whether the CBA's layoff provisions created rights and obligations that continued after the agreement expired. The Court noted that one circumstance in which "a post-expiration grievance can be said to arise under the contract" is "where an action taken after expira-

tion infringes a right that accrued or vested under the agreement," and the Court explained that other rights also can continue to be enforceable after expiration of the CBA if "normal principles of contract interpretation" show that that the parties intended to provide that the contractual obligation in question was to continue in force. 501 U.S. at 206. Applying that analysis, the Court concluded that the use of seniority as one factor in determining which employees would be laid off did not constitute a "form of deferred compensation for time already worked," *id.* at 209, and therefore did not create accrued or vested rights like the severance pay provision in *Nolde*, which, as the *Litton* Court recognized, "was viewed as a form of deferred compensation," *id.* at 210.[7]

b. M&G patently distorts *Litton* when it says *Litton* held

> that "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement" unless the "collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration."

Pet. Br. 17. The two quoted excerpts that M&G stitches together with the condition "unless" are connected by no such condition. The full passage is this:

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[7] Although the *Nolde* Court did not decide the merits of the severance pay dispute, holding only that it should be arbitrated, it observed that severance pay scaled to years of service and salary could be regarded as deferred compensation. 430 U.S. at 248 n.4, 249.

> [O]ther contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement. Exceptions are determined by contract interpretation. Rights which accrued or vested under the agreement will, as a general rule, survive termination of the agreement. And of course, if a collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration, disputes as to such continuing benefits may be found to arise under the agreement.

Litton, 501 U.S. at 207.

The reference to "explicit terms" in the final sentence, beginning as it does with "And of course," is plainly given as just one of several circumstances in which a court should find that an obligation continues post-expiration.[8] No parsing of language could lead to the conclusion that *Litton* holds that "explicit terms" are required in order for a contractual obligation to continue after the contract has expired, for in *Litton* there were no explicit terms stating that the arbitration obligation would continue (and there was a provision requiring compliance with the contract "until the date of expiration and no longer"), and the Court held nonetheless that the arbitration promise continued after the contract expired. In addition, the *Litton* Court recognized that a CBA promise in the nature of deferred compensation, such as the sever-

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[8] No party argued in *Litton* that applicable principles of contract interpretation require "explicit terms" before a right—even one that does not "accrue" or "vest"—can survive expiration of the agreement, nor did the Court cite any authorities that espouse such a proposition.

ance pay at issue in *Nolde*, could survive expiration of the agreement, despite the absence of any explicit terms so providing.

An "explicit terms" requirement also would be at odds with the *Litton* Court's recognition that employers may remain bound by "express *or implied* terms of the expired agreement," 501 U.S. at 203 (emphasis added), and that "obligations already fixed under the contract but as yet unsatisfied," *id.* at 206, which must be satisfied after the agreement has expired, include "form[s] of deferred compensation," *id.* at 210.

3. M&G also claims to find support for an "explicit terms" requirement in other authorities, but it misreads the sources it cites.

In *John Wiley & Sons, Inc. v. Livingston*, 376 U.S. 543 (1964), this Court did *not* state that an intention that a provision will survive the termination of a CBA "must be clearly spelled out in the agreement itself." Pet. Br. 17. What the Court actually stated was that it was not "plainly unreasonable," 376 U.S. at 555, for the union to maintain that its post-expiration grievances concerned matters as to which the parties had "agree[d] to the accrual of rights during the term of [the] agreement and their realization after the agreement had expired," *id.*

M&G attributes to Professor Farnsworth the proposition that "benefits" are not established in the first place "without a clear intent on the face of the agreement to confer [those] benefits." Pet. Br. 16, citing A. Farnsworth, *Contracts* §§ 3.1, 3.3 (1982). The sections of the Farnsworth treatise M&G cites, which

address the baseline requirements of assent and definiteness, and offer and acceptance, in the formation of an enforceable contract, do *not* require that "benefits" be established by "a clear intent on the face of the agreement"; such a requirement would be at odds with what Farnsworth describes as "the overarching principle of contract interpretation . . . that the court is free to look at all of the relevant circumstances surrounding the transaction." A. Farnsworth, *Contracts* § 7.10 p. 467 (3d ed. 1999).

M&G also contends that, "as the duration and cost of the supposed promise increase," "so does the level of formality required to conclude that a promise exists." Pet. Br. 22 (quoting *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 618 (7th Cir. 1993) (Easterbrook, J., dissenting)). *See also* ERIC Br. 12. However, the dissent M&G quotes relied on authorities dealing with the special interpretive problems posed by "contracts providing for some *perpetual or unlimited* contractual right." *William B. Tanner Co. v. Sparta-Tomah Broad. Co.*, 716 F.2d 1155, 1159 (7th Cir. 1983) (emphasis supplied). As the *Bidlack* majority recognized in rejecting the dissent's analysis, retiree health obligations are *not* perpetual. *See* 993 F.2d at 607 (Posner, J.) ("[T]he obligation for which the plaintiffs contend in this suit is not perpetual, because retired people and their widows (or widowers) do not live forever."). *See also Int'l Union, UAW v. ZF Boge Elastmetall LLC*, 649 F.3d 641, 648 (7th Cir. 2011) (explaining that post-expiration retiree benefits are unlike the "perpetual" obligations at issue in *Tanner*); 3 A. Corbin, *Corbin on Contracts* § 553 (1960) at 212-15 (explaining, in a section entitled "Promises of Performance Without a Time Limit," that a "promise to do, or not to

do, some act or series of acts in perpetuity," is to be distinguished from a promise "to pay a specified pension, or retirement allowance, or other compensation 'for life,'" as the latter kind of promise presents "no special problem of interpretation").

4. As M&G points out, Pet. Br. 25-26, in *International Union, UAW v. Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999), the Third Circuit stated that, "[b]ecause vesting of welfare plan benefits constitutes an extra-ERISA commitment, an employer's commitment to vest such benefits is not to be inferred lightly and must be stated in clear and express language." That proposition rests on three distinct and fatal errors.

First, Skinner Engine assumes that an employer will not wish to provide any benefits beyond whatever is required by law. That assumption ignores that employers use their total compensation packages to compete for employees (which is one reason why most employers pay more than the minimum wage). *Second, Skinner Engine* assumes that in collective bargaining, employers that do not wish to provide any more than the law requires will succeed in obtaining union agreement to that position. *Third, Skinner Engine* proceeds on the erroneous notion that if something is "not to be inferred *lightly*," it cannot be inferred from anything but "*clear and express language.*"

In sum, nothing in this Court's caselaw, or in traditional rules of contract interpretation, or in ERISA, supports the Third Circuit's *Skinner Engine* rule.

5. M&G and its *amici* suggest that an "explicit terms" requirement should be adopted as an in-

terpretive rule for construing CBA retiree health provisions in order to simplify the task of interpreting such provisions. Even if such a new rule would have merit as applied to *future* agreements, courts may not impose *post hoc*, in the interests of clarity for the future, an interpretive rule of which contracting parties were not on notice when they made their contract, and which would result in their agreements being construed contrary to their intent. For parties bound by a contract already negotiated, "[a new] default rule comes too late for them—*the bargain has been struck.*" *Bidlack*, 993 F.2d at 612 (Cudahy, J., concurring in the judgment) (emphasis in original).

But even for future agreements, clarity would be equally served by a presumption *in favor of* construing retiree health benefit promises as continuing beyond contract expiration as by a presumption *against*. And, as much as M&G and its *amici* extol the advantages employers would receive from an "anti-vesting" presumption, they ignore that the result would be to shift costs to retirees who generally live on modest fixed incomes. Nothing in the principles of contract interpretation or anything else calls for adopting a legal rule aimed at accomplishing that result.

Running through the briefs of M&G and its *amici* is the suggestion that it would be unreasonable to conclude that an employer would agree to an arrangement under which retiree health obligations would continue for a retiree's lifetime, because the expense involved may be substantial and unpredictable. But, to whatever extent such concerns might make an employer wish to

limit its obligations,[9] an employer cannot simply dictate what will be in its collective bargaining agreement. Such an agreement must reconcile the competing interests of *both* parties, in a context where, to achieve a substantial benefit in one area, a party may agree to substantial concessions in other areas.

Employers, of course, may not want to agree to a retiree health obligation that cannot be unilaterally terminated or changed after retirement. But by the same token, unions may not want to agree to a retiree health obligation the employer may unilaterally terminate or change to the detriment of retirees living on fixed incomes, with the employer having no post-retirement duty to bargain over the benefits to be provided to retirees, and with the union having no right to exert economic pressure in the event that the employer eliminates or reduces such benefits.[10] The stakes are equally high for both parties.

In addition to those considerations, to presume that a union has agreed to an arrangement under which the employer is entitled to eliminate health ben-

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[9] Although many employers today may have strong concerns about the present and potential costs of retiree health benefits, that was not necessarily the case in the days before substantial healthcare inflation. For example, it was not until 1991 that Goodyear negotiated agreements (not applicable to Apple Grove) to cap its costs with respect to future retirees. *See supra* at 5.

[10] *See Allied Chem. & Alkali Workers v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 181 n.20 (1971) (benefits for employees already retired are not a mandatory subject of bargaining); *NLRB v. Wooster Div. of Borg-Warner Corp.*, 356 U.S. 342 (1958) (a party to a collective bargaining relationship may not insist to impasse on a proposal regarding a non-mandatory subject of bargaining).

efits on the date the agreement under which an employee retired expires is to presume that the union did not take into account that such benefits are a form of deferred compensation for decades of service the retired employee has provided to the employer, and that one or two years of benefits does not come close to providing a retiree deferred compensation in satisfaction of those many years of service.[11] For retirees involved in this case, the 95-point rule meant that an employee who retired at age 65 generally would have had to work for the Company for *30 years* in order to earn a "full Company contribution" toward health benefits costs. It is not reasonable to presume that in negotiating retiree health benefits, a union will proceed on the view that what is due an employee for such service is a retirement benefit that the employee stands to lose after only a year or two of retirement (if that).[12]

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[11] We use the term "deferred compensation" in accordance with its common usage as reflected in *Nolde* and *Litton*, to describe a financial benefit that is earned through a specified period of employment and received after the employment has ended. *See, e.g.*, *Bidlack*, 993 F.2d at 620 (Cudahy J., concurring) ("Healthcare after retirement is deferred compensation"); Financial Accounting Standards Board, Statement of Financial Accounting Standards No. 106 (Dec. 1990), ¶ 146, *available at* www.fasb.org/summary/stsum106.shtml (last accessed 9/11/14) (explaining, with regard to retiree health benefits, that "[p]ostretirement benefits are . . . part of an employee's compensation for services rendered. Since payment is deferred, the benefit is a type of deferred compensation").

[12] *Lewis v. Benedict Coal Corp.*, 361 U.S. 459 (1960), is instructive in this regard. In that case the Court considered an employer's argument that "the union's breaches of its promises should give rise to a defense against the duty assumed by an employer to contribute to a welfare fund . . . ." *Id.* at 471. The

Thus, in collective bargaining, employer concerns about potential costs of long-term retirement benefits are met by union concerns about the potential impact on retirees of the potential loss of such benefits. No basis exists to presume that this clash of interests eventuates in an agreement on retiree health benefits that incorporates the employer's favored position rather than the union's. Faced with the need to reconcile these competing interests, unions and employers have in fact arrived at any number of resolutions, depending on the circumstances, including the parties' relative bargaining power and the trade-offs they can accept involving other elements of the compensation package.

Thus, some bargaining parties may have decided that retiree health benefits should not be subject to change in any respect during a retiree's lifetime. *E.g.*, *Trull v. Dayco Products, LLC*, 329 F. Supp. 2d 658, 669-70 (W.D.N.C. 2004), *aff'd*, 178 F. App'x 247 (4th

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Court recognized that, "in the generality of third-party beneficiary contracts," there may be "reasons making it appropriate" to "infer . . . an intention" that a third party's right to performance by the promisor is dependent on faithful performance by the promisee. *Id.* at 468. But, mindful of the fact that the employer contributions to the Welfare and Retirement Fund in that case were "to provide security for employees and their families to enable them to meet problems arising from unemployment, illness, old age or death," *id.*, the Court reasoned that the welfare plan contributions "are really another form of compensation to the employees," and to construe the CBA as allowing the employer to withhold those contributions in order to offset damages caused by the union's breach of contract would be no more reasonable than to suggest that the employer "might recoup its damages by decreasing [the] wages [specified in the agreement]," *id.* at 469.

Cir. 2006). Others may have decided that such benefits should be subject to change if, but only if, the union and employer mutually agree. *E.g.*, *Keffer v. H.K. Porter Co.*, 872 F.2d 60, 63 (4th Cir. 1989). Others may have decided that retiree benefits will be subject to modifications that are made in the insurance program for active employees but no others. *E.g.*, *Bidlack*, 993 F.2d at 610 ("A vested right to benefits equal to and hence varying with those of the active employees would give the retirees a good deal of protection, since health benefits are an important fringe benefit.")[13] Some may have agreed that reasonable changes in deductibles, copayments and related provisions will be allowed as long as the fundamental nature of the benefits remains the same—as the courts below found to be the intent of the agreements here. PA22-23, 76-86.[14] Others may have agreed that retirees

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[13] As the discussions of "vesting" in the cited cases reflect, that word can be used in a number of different senses. Sometimes it is used to refer to benefits that, once created, can never be altered in any way. And sometimes it refers to a right to benefits that can "vary[ ]," *Bidlack*, 993 F.2d at 610, but only as contemplated by the contract that created the right. Where the asserted rights depend on contract, the question is simply to determine what rights the parties created in that contract. To the extent we refer in this brief to "vested" benefits, we refer to benefits that cannot be changed except in ways, if any, that are permitted by the contract that created the rights.

[14] The district court found that the parties' actions in negotiating certain changes in benefits evinced an understanding that the agreements permitted such changes. *See supra* at 12; PA83, 86. Respondents do not believe that the evidence in this case supported that finding, and pursued a cross-appeal on the point, but did not cross-petition for certiorari; consequently, that matter is not before the Court.

may be required to pay contributions for their benefits if specified conditions occur—as would have been the situation here if the cap letters that were in effect at other facilities had been adopted at Apple Grove, as M&G contended but both courts below found not to have been the case. *See supra* at 10-13; *e.g.*, *Quesenberry v. Volvo Trucks N. Am. Retiree Health Benefit Plan*, 651 F.3d 437, 440-42 (4th Cir. 2011).

And of course, some parties may agree to what M&G seeks here: an unrestricted right on the employer's part to reduce or eliminate benefits for retired employees as soon as the CBA under which they retired has expired. There may be circumstances where, all things considered, a union finds that its best option is to agree to such an arrangement. But, for the reasons discussed, there can be no *presumption* that this, rather than any of the other possible arrangements, is the arrangement to which a particular union and employer have agreed.[15]

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[15] Contrary to the assumption reflected in the *amicus* brief of Goldstein & Russell, P.C., the intent of parties to a CBA regarding the duration of retiree medical benefits often is not expressed in a single phrase of an agreement; and it is a fundamental rule that "a writing is interpreted as a whole." Restatement § 202(2); *see infra* at 39. The relevant provisions in this case, discussed *infra* at 40-42, 45-46, 49-52, do not fit neatly into the taxonomy set out by Goldstein. Furthermore, the statements in the Goldstein brief regarding the relative frequency of various kinds of provisions are unreliable, not only because of the arbitrary nature of the taxonomy employed, but because half of the agreements in the very limited sample are from the public sector, where CBAs are negotiated under varying state and local laws and constitutions, such that the terms thus negotiated may not fairly be compared to private-sector agreements that are negotiated under the National Labor Relations Act and enforced through the LMRA.

C. ERISA Does Not Establish A Presumption That Rights To Retiree Health Benefits Continue Only As Long As The Agreement That Was In Effect When An Employee Retired

M&G and its *amici* make much of the fact that for pension plans, ERISA imposes vesting, accrual, participation, and minimum funding requirements "that cannot be bargained away," Pet. Br. 4, whereas for welfare plans, all those matters are subject to whatever terms parties may agree in collective bargaining to adopt. M&G would have it that this aspect of ERISA represents a "congressional assessment under ERISA that welfare benefits should not vest unless there is an express agreement that they should." *Id.* 25. M&G's *amici* go so far as to declare that, "[b]y exempting health and welfare plans from its vesting and anti-cutback rules, ERISA grants plan sponsors the unfettered, statutory right to terminate or modify such plans and to discontinue or decrease any benefits provided thereunder," unless the employer "waive[s] its ERISA rights to amend or terminate welfare benefits . . . through clear, express, and unmistakable language." Whirlpool Br. 6, 8. *See also* NAM Br. 20; ERIC Br. 12; CLLE Br. 9.

Like the presumption that was unsuccessfully advocated by the petitioners in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), the presumption against welfare benefit vesting that M&G and its *amici* would draw from ERISA lacks a basis in the statutory law.

In ERISA, Congress enacted highly specific vesting

and accrual requirements for pension benefits.[16] As M&G recognizes, these requirements are imposed regardless of the plan sponsor's intent, and "cannot be bargained away." Pet. Br. 4. Thus, the pension requirements are imposed by *law*, without regard to the intent of the parties who adopted the plan. That the ERISA Congress did not similarly impose mandatory vesting requirements on welfare benefits does not even remotely suggest a congressional purpose to curtail the parties' preexisting rights to determine through collective bargaining whether the welfare benefits they negotiate will continue beyond the term of their CBA.

The "congressional assessment" M&G posits, Pet. Br. 25, is *not* evidenced by the statement M&G cites from the 1974 House Report, that "[t]o require the vesting of these ancillary benefits would complicate the administration and increase the cost of plans whose primary function is to provide retirement income." Pet. Br. 6, quoting H. Rep. No. 807, p. 16, *reprinted in* 1974 U.S.C.C.A.N. 4670, 4726 (1973).[17] That statement

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[16] For defined benefit plans, pension benefits must accrue ratably over a participant's service in accordance with a statutory formula that prevents backloading, *see* 29 U.S.C. § 1054; *see generally Kifafi v. Hilton Hotels Ret. Plan*, 701 F.3d 718, 722 (D.C. Cir. 2012); and benefits derived from employer contributions must vest (*i.e.*, become nonforfeitable) in accordance with either of two statutorily-prescribed schedules, under which the longest period of service that can be required before vesting is seven years, 29 U.S.C. § 1053.

[17] The same language appears in S. Rep. No. 93-383, p. 51, *reprinted in* 1974 U.S.C.C.A.N. 4889, 4935 (1973). *See Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe R.R. Co.*, 520 U.S. 510, 515 (1977) (quoting this language but omitting the final eight words).

refers to *pension plans* that offer welfare programs as "ancillary benefits," and it expresses a concern that a statutory requirement that those ancillary benefits be "vest[ed]"—presumably under the strict statutory vesting rules that apply to pensions, *see* note 16 *supra*—might adversely affect "plans whose primary function is to provide retirement income." That observation does not relate to this case, in which retiree health benefits are not provided out of pension plan assets and the retirees are not seeking anything like the prescriptive vesting arrangements Congress mandated for pension plans.

And at least equally to the point, in explaining why pension plans should not be "require[d]" *by statute* to vest "ancillary" benefits, the House Report did not suggest that parties should be limited in their right to *agree* that retiree health benefits will vest; nor did the Report suggest that such an agreement should not be allowed unless it is stated in "express" terms, Pet. Br. 25.

Finally, even if M&G's interpretation of the ERISA Congress's views regarding retiree health benefits were not as unfounded as it is, a congressional "assessment" (*id.*) is not a *law*. In view of the fact that ERISA "was enacted ... to protect contractually defined benefits," *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (internal quotation marks omitted), and the statute provides that "nothing in [the statute] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States," 29 U.S.C. § 1144(d), an "assessment" evidenced by congressional inaction or by a statement in a committee report is not the equivalent of, or a substitute for, a congressional en-

actment, and such an "assessment" cannot possibly trump parties' rights to enforce through LMRA Section 301 their lawfully bargained agreement.

There consequently is no foundation for Whirlpool's argument that Congress conferred on employers and plan sponsors a "statutory right" to modify or terminate welfare benefits, which statutory right could be "waive[d]" only through "clear, express, and unmistakable language," Whirlpool Br. 8. One searches ERISA in vain for a provision creating such a right. No such provision exists, because Congress had not the slightest intention of preventing or limiting the enforcement of *negotiated agreements* regarding the continuation of welfare benefits.

II. TRADITIONAL RULES OF CONTRACT INTERPRETATION SUPPORT THE JUDGMENT BELOW

As we have shown, M&G's principal contention—that the Court should adopt an interpretive rule that retiree health benefit obligations do not continue beyond the expiration date of the agreement in effect when an individual retires unless the agreement provides in "explicit terms" that the obligations do continue—cannot be squared with the traditional rules of contract interpretation that govern the intrepretation of CBAs. M&G's alternative contention is that, if there is no "explicit terms" requirement, then the Court should adopt what M&G says is the interpretive rule followed by other courts of appeals that "there must be language in the agreement capable of being reasonably interpreted as a promise of vesting;" and M&G asserts that there "is no such language in the agreement here." Pet. Br. 30, 34. In what follows we show that M&G's alternative contention also fails.

A. Traditional Rules Of Contract Interpretation Require Only That The Parties' Language Be "Reasonably Susceptible" To The Asserted Meaning When Read In The Context Of All Related Agreements And The Parties' Course Of Performance

Traditional principles of contract interpretation simply require that the language of a contract, read in context, be "reasonably susceptible" to the asserted meaning. Restatement § 215, cmt. b (1981). In considering whether a contract's words are "reasonably susceptible" to an asserted meaning, a court does not consider a single phrase or clause in isolation. It is a "cardinal principle of contract construction[] that a document should be read to give effect to all its provisions and to render them consistent with each other." *Mastrobuono v. Shearson Lehman Hutton, Inc.*, 514 U.S. 52, 63 (1995); *see also* Restatement § 202(2). And the parties' words must be considered in light of their course of performance, because what parties actually do under a contract provides "highly significant" evidence of what they understood the contract to mean. *Alabama v. North Carolina*, 560 U.S. 330, 346 (2010); *see also* Restatement § 202(5).

The Court has held that these traditional rules apply fully to the interpretation of CBAs. "In order to interpret such an agreement it is necessary to consider the scope of other related collective bargaining agreements, as well as the practice, usage and custom pertaining to all such agreements." *Transp.-Commc'n Emps. Union v. Union Pac. R.R. Co.*, 385 U.S. 157, 161 (1966).

Nothing in these principles allows for the impo-

sition of a vaguely defined requirement that some particular kind of language must be employed if a CBA's retiree health promises are to continue in force, after the agreement's expiration, through retirement. Instead, the task for the courts is to consider the language the parties actually used in their agreement considered in the context provided by all their agreements and their course of performance, and determine what they actually intended.[18]

B. Under Traditional Rules, The Agreements Were Reasonably Interpreted To Provide That The Retiree Health Benefits Were Promised For Life

The language of the Apple Grove retiree health benefit provisions, read in context, is "reasonably interpreted as a promise of vesting," Pet. Br. 30, and that intepretation is the only one that is consistent with the employers' course of performance.

1. The Language Of The Retiree Health Promise Is Reasonably Susceptible To The Lower Courts' Interpretation

a. The P&I agreements provided for a benefit—the "full company contribution" for health benefits after retirement—that was due upon completion of

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[18] This case does not present an occasion to decide whether a contract must first be found ambiguous before evidence of course of performance (or any other evidence) is admissible to show the parties' intent. In the proceedings below, M&G relied on extrinsic evidence from the very first, *supra* at 7, 10, and asserted no objection to any evidence in the record based on an argument that the agreements were unambiguous and that such evidence therefore could not be considered.

lengthy service and was proportioned to the length of the service. Under the 95-point formula, an employee retiring at age 65 generally needed 30 years of service to receive this benefit. Employees with fewer points received a reduced employer contribution based on the difference between their point totals and 95. *Supra* at 3. This kind of retirement benefit is reasonably understood to constitute a form of deferred compensation—something to be paid to an employee in the future in consideration of the employee's lengthy service. *Nolde*, 430 U.S. at 248 n.4.

b. The contracts also addressed the length of time for which these benefits would be payable. They provided that retirees "who are eligible for and *receiving* a monthly pension" "will receive" the full company contribution toward health benefits. *Supra* at 3 (emphasis supplied). *See also* JA218 (employee "who retires and receives a monthly pension . . . shall have his medical benefits after retirement provided under Exhibit B"). The phrase "eligible for and *receiving* a monthly pension" is more than an eligibility provision. If it were just an eligibility provision, it only would need to say "eligible for a monthly pension." Instead, it adds the word "receiving"—using the verb form that describes a continuing process. And it does so in a context where both parties well understood that retirees "receiv[e] a monthly pension" from the date of retirement until death. *See* JA366-69. The language thus is most naturally read to provide health benefits for that entire period.

c. That understanding is reinforced by the agreements' provision that, after an eligible retiree dies, the

spouse is "entitled to continue to receive the benefits of this Exhibit B-1 until death or remarriage," *supra* at 4. This provision both states that surviving spouses are entitled to lifetime benefits unless they remarry, and confirms that the parties intended the retirees themselves to have lifetime benefits, as a promise of lifetime benefits to spouses after a retiree's death makes sense only if the retiree himself had a lifetime benefit.

d. The intent to provide lifetime health benefits to retirees is reinforced by the parties' use of open-ended phrases like "will receive" to create other benefits intended to last for a lifetime. The P&I agreements promised that life insurance would be "continued in force" for someone retiring directly from Apple Grove with a normal retirement pension. JA17. Someone who worked only until age 60, left, and later received a deferred vested pension, was promised similar coverage using the explicit term "during his lifetime." JA18. Both of these promises must have been intended to create a lifetime benefit, because it is not plausible that the parties would intend to give someone who worked faithfully until retirement anything less than someone who left before retirement age. As the parties used "continued in force" to describe a lifetime benefit in life insurance, their use of "shall receive" and "shall have his medical benefits after retirement provided" should equally be understood to intend a lifetime promise of health benefits, lasting as long as the retiree is "receiving a monthly pension."

2. **The Employers' Course Of Performance Is Not Consistent With Any Other Interpretation**

The employers' course of performance in provid-

ing health benefits to retirees is consistent only with the employers' understanding that the promises to provide those benefits continued in force after the expiration of the agreement in effect when an employee retired.

a. The 1997 P&I agreement was silent about health benefits for employees who had retired before January 1, 1996, instead describing such benefits only for "Employees who retire on or after January 1, 1996 and who are eligible for and receiving a monthly pension . . . ." JA263. Shell nonetheless continued to provide health benefits to the pre-1996 retirees while the 1997 P&I agreement was in effect, and M&G assumed the liability to provide health benefits for pre-1996 retirees as part of its purchase price for the facility. *Supra* at 2, 4. The 2000 P&I agreement was to the same effect as the 1997 Agreement, and M&G continued to provide health benefits to Shell's pre-1996 Apple Grove retirees. *Supra* at 4-5. Shell's and M&G's post-1997 payment of those benefits is highly significant evidence that the parties intended and understood the health benefit promises in their CBAs to be promises that continued in force after the agreement expired. That the employers understood this to be a binding obligation is confirmed by the agreement between Shell and M&G that, for assuming Shell's retiree health obligation, M&G would receive a credit against the purchase price for the Apple Grove facility in the amount of the full actuarial value of the retiree health benefits, calculated on the assumption that the benefits were for life. *Supra* at 2.

b. Further evidence that the employers understood that the promise to provide retiree health benefits

continued in force after an agreement expired is found in the way the employers dealt with the Medical Necessity Program. In 1994 negotiations, the parties agreed to discontinue that program for active employees as of December 31, 1994.[19] They entered into a side letter stating that "[e]mployees who retire prior to January 1, 1995" (a date that was later extended to 1997, *see* JA194) could still choose that program, "with coverage to be effective on the date of their retirement." JA192-93. The parties thus permitted an employee to elect the Medical Necessity Program as his retiree benefit program as long as he retired at any point *up to the date on which the Medical Necessity Program was to terminate.*

Authorizing such an election only made sense on the parties' mutual understanding that the retirees' entitlement to benefits thus elected would continue after the expiration of the agreement under which they retired.[20] No subsequent P&I agreement provided for the Medical Necessity Program, and no active employees received these bene-fits after 1997, yet at the time of trial M&G was still providing these benefits to pre-1997 retirees who had timely elected them. *Supra* at 4.

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[19] *See* R186 at 3-4, 78, 82, 85.

[20] Consistent with these facts, when the termination of the Medical Necessity Program was imminent, and an employee who was about to retire asked the employee's benefit office whether he would continue to receive Medical Necessity benefits after the termination date if he elected coverage before that date, he was told that he would. JA497-98.

3. Other Provisions In The P&I Agreements Confirm This Intent

Other provisions in the agreements also reflect the parties' intent that retiree health benefits continued in force after the P&I agreement in effect when an employee retired had expired.

a. The P&I Agreements contained provisions pertaining to retiree health benefits that could only take effect after an agreement terminated. Most notably, the 1994 agreement provided that in the event there was "a change in the plan design," retirees who were required to pay contributions for their health benefits (*i.e.*, those with fewer than 95 points) would be given an opportunity to change the benefit option they had elected, JA190, yet no provision in the P&I agreement allowed for plan designs to be changed during the term of a P&I agreement. Consequently, this provision could not take effect during the 1994 P&I agreement, thereby evidencing the parties' mutual understanding that retiree health benefits would continue after that agreement had terminated.

b. The P&I Agreements also promised retiree benefits to certain employees as long as 10 years after they left the employer's service—and none of the P&I Agreements were written with such a long term. For example, employees who left the employer's service after reaching age 60 with entitlement to a deferred vested pension starting at a later date were promised retiree health benefits beginning when the pension started. JA75. Similarly, those who retired before age 65 were promised that the Special Medicare Benefit would begin upon "the attainment of age 65," JA78-79, even though in many cases of early retirement, the re-

tiree would not reach 65 during the term of the P&I agreement.[21]

c. The Goodyear cap letters—although not applicable at Apple Grove—are further evidence that the parties understood that retiree health benefits would continue after the expiration of the then-current agreement. To take the 1991 agreements as an example, the P&I Agreement, which contained the "for the duration" language on which M&G relies, was accompanied by a letter stating that "[t]he Company *shall provide* health care benefits" as described in the P&I Agreement, subject to a dollar limit that would take effect no earlier than July 1, 1997—more than three years after the stated term of the agreement. *Supra* at 5-6.

C. The Duration Clauses Did Not Terminate Retiree Health Benefits

Ignoring this evidence of the parties' intent and course of performance, M&G argues now—for the first time in these lengthy proceedings—that "dura-

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[21] M&G quotes a portion of the eligibility rule for the Special Medicare Benefit (which reimbursed eligible individuals for a portion of Medicare Part B premiums, *see* JA139-40), arguing that it shows that the parties understood there must be circumstances in which a pensioner would no longer be covered by retiree health benefits under the P&I Agreements, thus proving that the health benefits were not vested. Pet. Br. 37. This argument is readily refuted by the recognition that retirees with fewer than 95 points were required to pay contributions to maintain their health coverage. The possibility of losing coverage based on failure to pay—a condition that was part of the agreement when these individuals retired—is fully consistent with an intent to create vested benefits subject to specific conditions.

tional language in the operative agreements indicates that the health-care benefits were to end with those agreements." Pet. Br. 34.

1. M&G's Argument From The Duration Clauses Is Not Properly Before The Court

As we detailed *supra* at 7-12, at no time in the proceedings below did M&G argue that the duration clauses limited the retiree health benefits at issue in this case. In the Petition for Certiorari M&G described the Apple Grove agreements as "silent" on the question of duration of retiree health benefits, defining such "silence" as "the absence of a durational term." Petition 14; *see also id.* 23 ("There is no factual dispute that the collective bargaining agreement at issue was silent on the duration of the health-care benefits conferred.") M&G offered this case as "an ideal vehicle for resolving" the question of "how to construe . . . contractual silence" about the duration of retiree health benefits. *Id.* 2. Now, M&G asserts the opposite: "with respect to the health-care benefits at issue in this case, [t]he agreement expressly limits those benefits to 'the duration of this Agreement.'" Pet. Br. 37 (quoting JA377). This is not offered as an alternative argument. *See id.* 34.

The Court's Rule 14.1(a) provides that "[o]nly the questions set out in the petition, or fairly included therein, will be considered by the Court." The question presented in M&G's petition was to determine the rule to be applied in intepreting a CBA where there is "silence concerning the duration of retiree health-care benefits." M&G's current duration-clause argument is not that question, nor is it "fairly included." Rather, that new argument asks only whether the particular

agreements in this case contain language that limited the duration of retiree health benefits, without regard to any broad question of how to interpret agreements that are silent. The Court should not consider this argument. *See Yee v. City of Escondido*, 503 U.S. 519, 536 (1992).

We could not have called this to the Court's attention earlier. As in *City of Springfield v. Kibbe*, 480 U.S. 257, 260 (1987), because M&G chose not to make the duration clause argument either below or in the Petition, Retirees had no notice that M&G believed that the language of the agreements "expressly limits" the duration of retiree health benefits at issue here or that M&G would so argue on the merits.

It was open to M&G under Sixth Circuit precedent, *see* Petition 14, to argue below what it now asserts to this Court, namely, that the Apple Grove duration clauses "expressly" limited those benefits. Because M&G chose not to do so, neither the district court nor the court of appeals considered whether the language of the agreements or the employers' course of performance supported M&G's "expressly limits" argument. As a matter of prudence, this Court "ordinarily will not decide questions not raised or litigated in the lower courts." *City of Springfield*, 480 U.S. at 259; *Medimmune, Inc. v. Genentech, Inc.*, 549 U.S. 118, 136 (2007). This case is ill-suited for an exception. Not only does M&G's current argument require analysis of detailed contract language that was not considered below, but Retirees had no notice that they should offer evidence relevant to that argument.

2. If The Court Considers M&G's New Argument, It Should Conclude That The Duration Clauses Do Not Limit Retiree Health Benefits

If this Court does consider on the merits M&G's new argument about what its agreements mean, the Court should conclude that the agreements' duration clauses do not limit retiree health benefits to an agreement's term. Indeed, M&G's own submission shows that the clauses do not impose such a limit.

a. Although M&G declares that the language of the duration clauses "plainly indicates that the health-care benefits were intended to last only as long as the agreement was in place," Pet. Br. 36, M&G acknowledges that the agreements' pension benefits, which were prefaced by the same duration language,[22] were

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[22] For example, the 2000 P&I Agreement states that "the [Pension] Plan . . . shall be continued in effect with respect to . . . Employees [covered by this Agreement] for the duration of this Agreement." JA335. The other clauses cited at Pet. Br. 35 are not materially different. *See* JA196-97 (Letter A provides that "for the duration of" the Basic Agreement, "the benefit plans currently applicable to employees" at Apple Grove "will be continued"); JA85 (1991 Exhibit B-1 to P&I agreement provides that "for the duration of this Agreement" Goodyear would "provide the following program of . . . health benefits . . . for eligible employees and their dependents").

M&G also quotes a 1994 Supplemental P&I Agreement ("this Agreement terminates on April 19, 1997 *and shall not be continued beyond that date*," JA97). Pet. Br. 35 (emphasis supplied). M&G asserts that other P&I Agreements and CBAs contain "similar language." Pet. Br. 35 n.9. In point of fact, none of the provisions M&G cites, nor any others that we have located, contain language similar to the "shall not be continued"

not intended to last only as long as the agreement was in place. *Id.* 37. To be sure, M&G argues that the "vesting" language in the pension article is explicit while the language in the health benefits article is not. *Id.* 36-37. We will show in a moment that the conclusion M&G seeks to draw from that asserted distinction is invalid. But in any case, M&G cannot and does not maintain that there is any relevant difference between the *duration clause* language that applies to those respective articles. Consequently, M&G's acknowledgment that pension benefits described in the P&I Agreement continue beyond the term of the agreement necessarily means that the duration clause language that applies equally to pension and to health benefits does *not*, by its own force, operate upon expiration of an agreement to terminate benefit obligations that arise while the agreement is in effect.[23]

b. Nor is there any force to M&G's alternative contention (unrelated to the interpretation of the duration clauses themselves) that, because the pension

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phrase. The explanation for that additional language is simple. The Supplemental P&I Agreement contained the agreement to continue the Medical Necessity Program until December 31, 1994. *Supra* at 4, 44. The language stating that the Supplemental P&I Agreement "shall not be continued" after that date served to make clear that the employer's concession in agreeing to continue the Health Necessity Program for three more years was intended to last for only that short term.

[23] The duration clauses lend themselves to several possible meanings. They could be understood to apply only to the benefits that the employer promised to provide for active employees, as each of the specific duration clauses in the P&I Agreements referred either to benefits "for regular full time employees" or

article uses specific language regarding nonforfeitability of benefits, the parties must have had a practice of using that kind of language whenever they intended that any kind of benefit arising under an agreement would continue after expiration. Such an inference, far from being compelled, is not even reasonable, because there is a ready explanation for the parties' use of specific language relating to nonforfeitability of pensions. ERISA requires that "[e]ach pension plan shall provide that an employee's right to his normal retirement benefit is nonforfeitable upon the attainment of normal retirement age. . ." 29 U.S.C. § 1053(a). Drafters of pension plans must take care to include such language.[24] No statute similarly requires that rights to continuing health benefits be expressed in any particular form of words. That the parties did not employ pension-like language to describe benefits that are not subject to similar statutory rules provides

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to programs of benefits that were themselves described as benefits "for employees and their dependents." *See* JA201, 218, 223, 335. Alternatively, the duration clauses could be understood to provide that the employer was obligated to continue the specific packages of benefits defined in a P&I Agreement without change (except as that agreement might authorize) during the term of the agreement, and to provide the same package of benefits during retirement to employees who retired during that term, with the employer having the right *thereafter* to make the limited kinds of changes that the courts below found permissible here, *supra* at 33.

[24] *See also* 26 U.S.C. § 401(a)(10)(B)(ii) (a pension trust "shall constitute a qualified trust under this section only if such plan contains [specified] provisions [relating to "top-heavy" benefits]"); Pet. Br. 37 (quoting "top-heavy" provisions in the Apple Grove pension article).

no ground for a negative inference as to the parties' intent.[25]

c. It bears repeating in this context that if Shell and M&G had understood that retiree health obligations were limited by the duration clauses, Shell would not have reduced M&G's purchase price by a *credit for* the health benefit liabilities for pre-1996 retirees that was calculated on the understanding that the duration of health benefits coverage was "Lifetime for Retirees and Spouses" and that retiree contributions were "None." JA323, 329-30.

D. This Agreement Is Not "Silent" On The Duration Of Retiree Health Benefits, And The Sixth Circuit's Judgment Does Not Depend On Any Presumption Based On Such "Silence"

It should be apparent from the foregoing that M&G is wrong when it asserts (apart from its new-found duration clause argument) that the P&I Agreements

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[25] The life insurance article also is preceded by similar duration language, *see supra* at 5, and contains no language describing retiree life insurance benefits as "vested" or "nonforfeitable." But, in addition to the life insurance benefits already discussed, *supra* at 42, the agreements provide optional contributory life insurance, under which an employee who elected supplemental coverage and made contributions for at least ten years leading up to retirement was promised in exchange a higher level of coverage after retirement. As an optional benefit fully paid by the employee before retirement, this coverage cannot be reconciled with M&G's argument that everything in the P&I agreement that was not labeled "vested" was intended to terminate when the agreement ended.

were "silent" on the duration of the retiree health benefit promise. *E.g.*, Pet. Br. 16, 27, 30, 41. The agreements required interpretation to determine the parties' intent in that regard, but they were far from "silent."[26]

It should also be apparent that M&G is wrong in asserting that the judgment below depends on a "presumption" that the Sixth Circuit supposedly applies to agreements that are silent about the duration of retiree health benefits. Pet. Br. 40-41. Even if Petitioners' parsing of the lower court's body of decisions had merit, no such presumption is needed here and this Court need not approve one, even implicitly, to affirm the judgment below. But the Sixth Circuit's caselaw is not as M&G describes it; instead it is consistent with the traditional rules for interpreting CBAs. The Sixth Circuit has been emphatic that its decision in *Yard-Man* did

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[26] M&G cites Seventh Circuit caselaw for the proposition that the "presumption" that retiree benefits expire with the contract can only be "knocked out by a showing of genuine ambiguity, either patent or latent, *beyond silence*." Pet. Br. 31-32 (quoting *Rossetto v. Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000) (M&G's emphasis). As we have shown in Part I, there is no such presumption. Nor, given the numerous contractual provisions we have discussed that bear on the duration of the retiree health benefits here, can the agreements properly be described as "silent" on that subject. Furthermore, in *Rossetto* the court recognized that "the silence of [a] collective bargaining agreement with respect to vesting [can] make[ ] the agreement genuinely ambiguous," 217 F.3d at 546; and the court found a latent ambiguity in the Pabst contract due, *inter alia*, to the fact that Schlitz, operating under the same language, had continued to provide retiree benefits after its CBAs were no longer in effect due to plant closings. *See id.* at 545-46.

not create a presumption in favor of vesting. *E.g.*, *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 261-62 (6th Cir. 2012). *Yard-Man* itself expressly holds that the continuation of retiree insurance benefits "depends on the intent of the parties," 716 F.2d at 1479. To determine what that intent is, traditional rules of contract interpretation are used to the extent consistent with federal labor policy. *Id.* Contract language is considered first, in "the context which gave rise to its inclusion," and each disputed provision is interpreted "as part of the integrated whole." *Id.* at 1479-80.

Yard-Man's "examination of the context in which the[ ] benefits arose," *id.* at 1482, is unexceptional, and the Sixth Circuit was correct in regarding that context as supporting "the likelihood that continuing insurance benefits for retirees were intended," *id.* That "such benefits . . . are typically understood as a form of delayed compensation or reward for past services," *id.*, is highly relevant to the question of their duration, as this Court recognized with respect to severance pay in *Nolde* and *Litton*. *See supra* at 23-24. Where, as here, the eligibility criteria for the benefits require lengthy service, and the benefits that are promised increase in proportion to an employee's length of service, it is reasonable to doubt that the benefits "would be left to the contingencies of future negotiations," 716 F.2d at 1482, in which continuation of the benefits would be "only [a] permissive not [a] mandatory subject[ ] of collective bargaining," *id.* *See supra* at 30 n. 10. And where, as in this case, the contract language makes continuing receipt of a pension, rather than simply some specified number of years of service, the factor that determines whether and when

retiree health benefits will be received, such language shows an intent that the benefits will be received as long as the pension is received. *See supra* at 40-41.

To be sure, those considerations, separately and together, are not *conclusive* as to the contracting parties' intent. But the Sixth Circuit does not say that they are. *Yard-Man* could hardly have been clearer on that point:

> This is not to say that retiree insurance benefits are necessarily interminable by their nature. Nor does any federal labor policy identified to this Court presumptively favor the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent. Rather, as part of the context from which the collective bargaining agreement arose, the nature of such benefits simply provides another inference of intent. Standing alone, this factor would be insufficient to find an intent to create interminable benefits. In the present case, however, this contextual factor buttresses the already sufficient evidence of such intent in the language of this agreement itself.

716 F.2d at 1482.

In this case, the Sixth Circuit did not discuss all of the related terms of the P&I Agreements or the evidence of course of performance, but that is because M&G did not argue below that the text of the P&I agreements should be interpreted as it now contends. What M&G argued in both courts below was that the parties at Apple Grove had adopted cap letters that authorized M&G to charge retirees for all costs in ex-

cess of a cap. *Supra* at 7-10, 12.[27] Although M&G failed on that issue, on credibility grounds, it cannot bring itself to acknowledge those adverse rulings anywhere in its brief and even now urges this Court to consider the cap letters in interpreting the Apple Grove agreements. *E.g.*, Pet. Br. 42 ("the evidence here (i.e., the cap agreements) makes plain that the benefits did not vest"). The cap letters are not part of the Apple Grove agreements. The courts below found sufficient evidence otherwise that the parties intended to create rights to health benefits continuing, without retiree contributions, as long as the retiree is receiving a pension. Their judgment should be affirmed.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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[27] The only argument that M&G made from the language of the agreements that applied at Apple Grove, rather than from the cap letters that did not apply, was that a "full company contribution towards the cost of the benefits" did not mean 100% of the cost, but just the amount up to any applicable cap. *Supra* at 8, 9, 12.

Respectfully submitted,

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REPLY BRIEF

RECORD AND BRIEFS

No. 13-1010

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In The
Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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TABLE OF CONTENTS

Page

REPLY BRIEF FOR PETITIONERS 1

I. Respondents Cannot Salvage The Judgment Below By Recasting *Yard-Man* As "Ordinary Contract Interpretation" 4

II. Respondents Do Not Dispute That The Agreement Lacks Clear And Express Language Vesting Health-Care Benefits 9

III. The Confusion Sown By The Sixth Circuit's Approach Underscores The Need For A Uniform, Consistent Text-Based Standard 17

CONCLUSION 24

TABLE OF AUTHORITIES

Page

CASES

Allis-Chalmers Corp. v. *Lueck*, 471 U.S. 202 (1985) 11, 12

Bidlack v. *Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993) 5, 14

Chesapeake & Ohio Canal Co. v. *Hill*, 82 U.S. 94 (1872) 17, 18

Cole v. *ArvinMeritor*, 549 F.3d 1064 (6th Cir. 2008) 19

Consol. Rail Corp. v. *Ry. Labor Execs. Ass'n*, 491 U.S. 299 (1989) 13

IBEW Local 1395 v. *NLRB*, 797 F.2d 1027 (D.C. Cir. 1986) 12

Int'l Union, UAW v. *Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999) 11

Lewis v. *Benedict Coal Corp.*, 361 U.S. 459 (1960) 7

Litton Fin. Printing Div. v. *NLRB*, 501 U.S. 190 (1991) ..... *passim*

Local 174, Teamsters v. *Lucas Flour Co.*, 369 U.S. 95 (1962) 22

NLRB v. *Am. Nat'l Ins. Co.*, 343 U.S. 395 (1952) 3

Nolde Bros., Inc. v. *Bakery Workers*, 430 U.S. 243 (1977) 14

Reese v. *CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) 2, 5

TABLE OF AUTHORITIES – Continued

Page

Tarrant Reg'l Water Dist. v. *Herrmann*, 133 S. Ct. 2120 (2013) 23

UAW v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983) ..... *passim*

Yolton v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006) 19

STATUTES

29 U.S.C. § 157, National Labor Relations Act § 7 12

29 U.S.C. § 185, Labor Management Relations Act § 301 12

REPLY BRIEF FOR PETITIONERS

To effectuate the intent of parties to a collective bargaining agreement, and provide the uniformity needed in national labor law, any commitment to vest health-care benefits should be clear and express in the language of the agreement. That standard aligns with this Court's precedent, with national labor policy, and with common sense given the gravity of the contractual obligation at stake. At a minimum, this Court should insist on affirmative language in the agreement that can be reasonably construed as a promise of unalterable lifetime benefits. Silence is not enough. This Court should reject the Sixth Circuit's *Yard-Man* presumption of unalterable, lifetime health-care benefits (along with its various corollaries) and reverse the judgment below.

But now, respondents try to put as much distance as they can between *Yard-Man* and the judgment in this case. They do not even attempt to defend the Sixth Circuit precedent that carried the day for them below until the tail end of their brief—and even then their defense denies the obvious presumption applied by that court. Instead, respondents argue that *Yard-Man* merely involves "ordinary contract interpretation." That argument, however, does not pass the straight-face test, as *Yard-Man* itself expressly states that the duration of retiree health-care benefits is not "subject to th[e] stricture" of ordinary contract interpretation. *UAW* v. *Yard-Man, Inc.*, 716 F.2d 1476, 1481 n.2 (6th Cir. 1983). And that is putting it mildly. The Sixth Circuit has applied *Yard-Man* in

twenty-one published decisions and found enforceable promises of unalterable, lifetime health-care benefits in all but two of them. Br. of National Association of Manufacturers as *Amicus Curiae* 13-14 & n.9, 34. As Judge Sutton has observed, *Yard-Man* "must mean something or else there would be no point in having it." *Reese* v. *CNH Am. LLC*, 574 F.3d 315, 321 (6th Cir. 2009).[1]

This case provides a particularly clear lesson in what *Yard-Man* means. The district court initially determined that respondents' claims should be dismissed at the pleading stage because the language of the collective bargaining agreement cannot be read to promise a lifetime of unalterable health-care benefits. Pet. App. 142-45. Applying *Yard-Man*, however, the Sixth Circuit interpreted that same language, "standing alone, as indicating an intent to vest" and reversed the district court's dismissal for failure to state a claim. *Id.* at 19. In this case, then, *Yard-Man* meant everything—as respondents, who invoked *Yard-Man* at virtually every opportunity in the courts below, well know.[2]

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[1] It is no accident that respondents chose to bring this litigation in the Sixth Circuit, selecting only named retiree plaintiffs domiciled in Ohio (rather than, say, in West Virginia, where the plant and numerous other retirees are located).

[2] Respondents cited or discussed *Yard-Man* repeatedly throughout the proceedings below, e.g., Union Resp. to Motion to Dismiss 3, 4, 20, 23, 32; Retirees' Resp. to Motion to Dismiss 3, 4, 5; *Tackett I*: Retirees' Opening Br. 15, 16, 18, 19, 20, 22, 23; Union's Opening Br. 22, 24, 45, 50, 51, 52; Retirees' Reply Br. 6, 9, 10;

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Yard-Man is many things, but "ordinary contract interpretation" is not one of them. There is nothing ordinary about manufacturing ambiguity out of vague notions of "context" and then using that same context to "resolve" the purported ambiguity. Moreover, to the extent *Yard-Man* operates to impose a substantive term—i.e., a promise to provide unalterable lifetime health-care benefits—on the parties to a collective bargaining agreement, it directly contravenes national labor policy, which is concerned with process, not results. See Br. of Chamber of Commerce & Business Roundtable as *Amici Curiae* 10 (citing *NLRB* v. *Am. Nat'l Ins. Co.*, 343 U.S. 395 (1952)). And Congress quite deliberately chose *not* to apply the vesting rules it adopted for pension benefits to welfare benefits like health care. See, e.g., Br. of ERISA Industry Committee & American Benefits Council as *Amici Curiae* 12.

The lack of any meaningful defense of *Yard-Man* by respondents only confirms that it is indefensible and should be rejected in no uncertain terms. Because *Yard-Man*'s erroneous vesting presumption infected all proceedings below, the judgment should be reversed.

Union's Reply Br. 16, 21; Union Resp. to Motion for Summary Judgment 37, 39, 59, 62, 67; Retirees' Resp. to Motion for Summary Judgment 12, 46; *Tackett II*: Respondents' Opening Br. 38, 39, 40, 41, 50, 63, 67; Respondents' Reply in Support of Cross Appeal 10, 11, 12, 13, 14.

I. Respondents Cannot Salvage The Judgment Below By Recasting *Yard-Man* As "Ordinary Contract Interpretation"

Respondents make no serious effort to defend *Yard-Man* on its own terms. Instead, they take a "nothing to see here, folks" approach, insisting that *Yard-Man* is nothing more than "ordinary contract interpretation." See Resp. Br. 15-46.

In opposing *certiorari*, however, respondents at least acknowledged that "traditional contract-interpretation rules" are "refined by * * * nuanced Sixth Circuit jurisprudence." BIO 9. If *Yard-Man* were as innocuous as respondents suggest, there would be little point for the Sixth Circuit to deploy it each time it is faced with a case regarding retiree health-care benefits in collective bargaining agreements—and virtually every time to find a promise of unalterable, lifetime health-care benefits in agreements that say nothing of the sort.

In the Sixth Circuit, the "context" of retiree health-care benefits has subsumed the text of collective bargaining agreements—and that, in turn, has allowed courts to use extrinsic evidence both to create and resolve perceived "ambiguity"—i.e., silence as to the duration of retiree health-care benefits.

Presumably because the Sixth Circuit knows that it has staked out a position that goes well beyond ordinary contract interpretation, it has claimed to disavow any presumption in favor of a promise of unalterable, lifetime health-care benefits while at the

same time "inferring" that very thing. One example captures the contradictions:

> Although we do not apply a "legal presumption that benefits vest" and although we require plaintiffs to bear the burden of proving that vesting has occurred, we apply an "inference" that "it is unlikely that [welfare benefits] would be 'left to the contingencies of future negotiations,'" so long as we can find *either* "explicit contractual language *or* extrinsic evidence indicating" an intent to vest benefits.

Reese, 574 F.3d at 321 (alteration in original) (emphases added) (citation omitted). The Sixth Circuit's "inference" squarely conflicts with the fundamental principle of "ordinary contract interpretation," properly understood, that extrinsic evidence should only be used to resolve ambiguous contract language. See, e.g., *Bidlack* v. *Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993) (en banc).

A. Try as they might, respondents cannot escape the reality that the *Yard-Man* presumption was dispositive in this case on the threshold legal issue whether the collective bargaining agreement contained a promise to provide unalterable health-care benefits for life. See Pet. App. 114. Indeed, the district court initially granted M&G's motion to dismiss respondents' claims in their entirety because that court determined (correctly) that as a matter of law, there is no language in the collective bargaining agreement evincing any such promise. Respondents are correct that after the Sixth Circuit reversed

that decision, the district court subsequently made credibility determinations in their favor as to *what* vested—but those determinations are utterly irrelevant to the question presented here concerning whether anything did actually vest. *Id.* at 64.

As the Sixth Circuit itself recognized, its prior holding in *Tackett I* established "a controlling interpretation of the [collective bargaining agreement] that prove[d] dispositive of at least the vesting issue, if not the issue of capped versus uncapped benefits." *Id.* at 61. The Sixth Circuit paid lip service to the notion that it did not decide the ultimate question, *id.* at 61-62, while at the same time referring to "an unqualified declaration" that "'the parties intended health-care benefits to vest.'" *Id.* at 62 (quoting *id.* at 114). The district court got the message and made factual findings on remand that aligned with its "conclusion that the Sixth Circuit answered the threshold vesting issue." *Id.* at 63. But the agreement is silent on that "threshold" issue—and typically, when an agreement expires, its provisions do not outlive it. *Litton Fin. Printing Div.* v. *NLRB*, 501 U.S. 190, 207 (1991). There is no getting around that *Yard-Man* dictated the conclusion that the benefits vested in this case as a matter of law—and the trial that followed on *what* actually vested has nothing to do with the threshold vesting issue before this Court.[3]

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[3] Respondents rely (at 30-31) on the principle that retiree benefits are essentially deemed "deferred compensation," but that argument proves too much. It would render vesting automatic

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The trial repeatedly invoked by respondents is thus unconnected with the vesting question before this Court. The bench trial simply determined "*what* vested"—not whether anything vested as an initial matter. Pet. App. 64 (emphasis in original). The Sixth Circuit had already decided that issue based solely on its application of *Yard-Man* to the collective bargaining agreement at issue. The district court was only "called upon to explain whether what vested include[d] specific benefits." *Ibid.* The fact findings on which respondents adamantly rely are thus irrelevant to this Court's resolution of the case, as M&G's arguments for reversal focus on the threshold vesting issue.

Respondents argue nonetheless (at 13) that the *Tackett II* panel "corrected the district court's misimpression that *Tackett I* had finally determined the question of vesting," a claim that is true as far as it goes—which is not very far. While the *Tackett II* panel did mention "the possibility that the district court might determine on remand that the Plaintiffs did not have vested benefits," Pet. App. 13, the key takeaway for present purposes is the Sixth Circuit's

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simply by virtue of the fact that the benefit at issue is being afforded to a retiree—and no court, not even the Sixth Circuit, has gone so far (although the Sixth Circuit's approach essentially has the same practical effect). And contrary to respondents' assertion (at 31-32 n.12), this Court's decision in *Lewis* v. *Benedict Coal Corp.*, 361 U.S. 459 (1960), does not help them. *Lewis* predated ERISA and Congress' careful consideration (and rejection) of welfare-benefit vesting.

holding in *Tackett I*—in no uncertain terms—that under *Yard-Man*, the district court reversibly erred in concluding that contract language promising a "full company contribution towards" (indicating not all) the costs of health-care benefits is not, as a matter of law, a promise of unalterable, contribution-free health-care benefits. Thanks to *Yard-Man*, after that reversal, the writing was already on the wall—and the district court received the Sixth Circuit's message loud and clear on remand.

B. Having ridden *Yard-Man* for all it was worth in the courts below, respondents now cast it aside, claiming (at 17) that "the judgment below rests on traditional rules of interpretation—not on any presumption in favor of vesting" and that "the Sixth Circuit has not proceeded on the basis of any such presumption." But respondents have affirmatively invoked *Yard-Man* throughout the many years of this litigation. See *supra* note 2.

After the Sixth Circuit reversed the dismissal of respondents' claims, respondents argued in *Tackett II* (paraphrasing *Yard-Man* only slightly) that "retiree benefits are in a sense 'status' benefits which, as such, carry with them an inference * * * that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree." Second Br. (Resp. Opening Br.) at 39, *Tackett II*, 733 F.3d 589 (6th Cir. 2013) (Nos. 12-3329, 12-3407) (citing *Yard-Man*, 716 F.2d at 1482). Respondents went on to claim that, "[i]n light of the *Yard-Man* directives and the inference that retiree benefits are intended

to vest, the [d]istrict [c]ourt correctly concluded [respondents] established that lifetime health care benefits have vested." *Id.* at 40.

Respondents' attempt to distance themselves from a method of contract interpretation that expressly allows courts to resort to extrinsic "evidence" to support an initial "inference" of vesting based solely on context (never mind text) is wholly unpersuasive. It is undeniable that *Yard-Man* has been embedded in this case from *Tackett I* forward. As a result, if *Yard-Man* falls, the judgment below cannot stand. In that regard, it is telling that respondents have apparently decided the only way to save *Yard-Man* is to pass it off as something else. That ploy only underscores that *Yard-Man* is indefensible on its own terms, and the only real question is what the proper standard of construction should be going forward.

II. Respondents Do Not Dispute That The Agreement Lacks Clear And Express Language Vesting Health-Care Benefits

The only interpretive standard that honors this Court's precedent, respects traditional rules of contract interpretation, and furthers national labor policy is one that requires an intent to vest benefits be expressed with sufficient clarity in a collective bargaining agreement to trump the expiration clause of that agreement—a standard not satisfied by the agreement here. As already demonstrated by M&G

and its *amici*, this clear statement rule—which has been adopted by the Third and Fifth Circuits—is the optimal approach to construing silence in collective bargaining agreements regarding the duration of retiree health-care benefits. Pet. Br. 13-14; 25-29; Br. of ERISA Industry Committee & American Benefits Council as *Amici Curiae* 10-16; Br. of National Association of Manufacturers as *Amicus Curiae* 5-25, 33-36; Br. of Council on Labor Law Equality & Society for Human Resource Management as *Amici Curiae* 4-24; Br. of Chamber of Commerce & Business Roundtable as *Amici Curiae* 5-23; Br. of Whirlpool as *Amicus Curiae* 30-33. That is so for several reasons.

First and foremost, it ensures adherence to traditional rules of contract interpretation. Pet. Br. 25-29. Given the background rules indisputably in place here—primarily Congress' deliberate decision to refrain from mandating that welfare benefits (as opposed to pension benefits) be vested, and this Court's general rule that terms expire with the collective bargaining agreements that contain them—silence on such a crucial point should not be treated as an invitation to extend the benefit beyond the term of the agreement. See Br. of ERISA Industry Committee & American Benefits Council as *Amici Curiae* 10-16. Nor should mere silence be enough to open the floodgates of discovery into "extrinsic evidence" that might support plaintiffs' interpretation. A clear statement rule prevents courts, however well-meaning, from violating the cardinal labor-law principle that courts must not impose substantive terms on the

parties to a collective bargaining agreement. Br. of Chamber of Commerce & Business Roundtable as *Amici Curiae* 10.

Additionally, a clear statement rule furthers the goals of national labor law by encouraging the parties to address the subject (as they should under principles of normal contract interpretation if vesting were intended) at the bargaining table rather than in the courtroom. A promise of unalterable lifetime healthcare benefits, as the Third Circuit has noted, is a substantial concession not to be imposed lightly by inference or presumption. *Int'l Union, UAW* v. *Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999). Further, as this Court has explained, Congress' policy of "interpretive uniformity and predictability" requires courts to construe collective bargaining agreements under "uniform federal law"—so that the parties can be certain "as to what they were binding themselves to when they agreed to create a right to collect benefits under certain circumstances." *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202, 211 (1985).

As the history of *Yard-Man* discloses, without a clear statement rule—or at least some form of a text-based rule—the employer choosing to provide any benefits to retirees will be the party in need of language *negating* vesting to avoid having to prove a negative down the line. Br. of Chamber of Commerce & Business Roundtable as *Amici Curiae* 12-13. A clear statement rule thus prevents courts from giving substantive weight to the parties' silence on an issue.

Perhaps most important, a clear statement rule would best serve national labor law's goals of uniformity and predictability by drastically reducing the odds that different courts will construe the same contract language differently, as is now unfortunately the case. See, e.g., *Allis-Chalmers Corp.*, 471 U.S. at 211 (invoking § 301 of the Labor Management Relations Act, 29 U.S.C. § 185, to justify preemption of state contract and tort actions based upon "[t]he interests in interpretive uniformity and predictability" of collective bargaining agreements). And represented workers will know their rights with certainty before litigation and independent of the circuit in which they live.

Respondents do not dispute—and thus concede—that the contract language here could not satisfy a clear statement standard. Instead, they take issue with the standard itself—relying heavily upon Judge Silberman's opinion for the D.C. Circuit in *IBEW Local 1395* v. *NLRB*, 797 F.2d 1027 (D.C. Cir. 1986), to argue against requiring clear textual evidence of an employer's promise of unalterable health-care benefits in perpetuity. But that case involved whether a collective bargaining agreement waived a *statutory* right—the right to engage in sympathy strikes, as established by § 7 of the National Labor Relations Act, 29 U.S.C. § 157—with the requisite "unmistakable" clarity. *Id.* at 1029. While the right to engage in sympathy strikes is a statutory right,

there is no statutory right to lifetime retiree health benefits.[4]

A clear statement rule is fully consistent with this Court's decision in *Litton*, which holds that "if a collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration, disputes as to such continuing benefits may be found to arise under the agreement* * * *" *Litton*, 501 U.S. at 207. Rather than seeing the essential point of *Litton*, respondents distort it to bolster their argument that continuing health-care benefit obligations do not need to be expressed in the terms of the agreement. This misses the point of *Litton* and misapplies its holding—at base, the case is about a *contractual* guarantee, and

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[4] In a further effort to avoid this conclusion, respondents misrepresent (at 22) the holding in *Consolidated Rail Corp.* v. *Railway Labor Executives Ass'n*, 491 U.S. 299 (1989). That case concerned whether an employer should have flexibility to act pursuant to a management-rights clause that gives an employer discretion to act in some circumstances. The union argued in that case that the employer could only act in ways specifically delineated in the contract. *Id.* at 308. This Court rejected the union's position, reasoning that labor law permits the parties to bargain for flexible contract terms, and such terms would be undermined if courts required a "clear and patent" statement of every action the employer might want to take pursuant to a management-rights clause. *Ibid.* The flexibility accorded by the management-rights clause at issue in *Consolidated Rail* has no bearing on the vesting issue presented in this case. If anything, it is clarity and uniformity—not "flexibility"—that is needed here.

not a term that continues as a statutory matter after the agreement expires.[5]

Litton involved an arbitration clause written into a collective bargaining agreement, and the question was whether that clause still applied to require arbitration after the contract terminated. While this Court noted that some contractual commitments can survive the termination of collective bargaining agreements—not as a matter of contract but as a function of the statutory status quo—it reaffirmed the general rule that contract provisions do not extend beyond the life of the contract itself.

Significantly, *Litton* involved an arbitration agreement, not a negotiated wage or benefit. It would make little sense for a requirement of arbitrability to cease with the contract, given that one reason for having arbitration is to resolve disputes that arose before the contract terminated. See *Bidlack*, 993 F.2d at 607-08 (en banc) ("The utility of an arbitration clause would be greatly impaired if the duty to arbitrate disputes arising under the contract expired with the contract, since such disputes might easily remain pending on the date of expiration. * * * [T]here is no similar structural necessity for a collective bargaining agreement to include an undertaking by the employer to pay lifetime medical benefits to retired employees* * * *"). And even though it was implicit,

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[5] Respondents over-read *Nolde Brothers, Inc.* v. *Bakery Workers*, 430 U.S. 243 (1977), for the same reasons.

the obligation was one that arose by the terms of the agreement itself—and the Court did not need to (and did not) look to extrinsic evidence or course of conduct to make a determination as to whether the provision applied. *Litton* is rooted in Congress' strong preference for arbitration and the common-sense recognition that disputes arising during the term of an agreement may not be fully and completely resolved while the agreement is in effect.

The guarantee of a health-care benefit, by contrast, has nothing to do with dispute resolution under the contract. As respondents note (at 22), "the purpose of an arbitration clause [is] to resolve disputes that arise under the contractual relationship." Retiree health-care benefits have no such purpose and—like the obligation to pay wages at specified levels and provide negotiated benefits—need not (and do not) survive the termination of the agreement under *Litton*.

In this case, unlike in *Litton*, a court would have to venture beyond the contract (to something such as *Yard-Man* "context") to justify vested benefits—a short trip, as it turns out, in the Sixth Circuit. Moreover, unlike arbitration, Congress has not expressed an affirmative desire for health-care benefits to continue beyond the term of a collective bargaining agreement; in fact, the available evidence suggests just the opposite. Pet. Br. 4-6, 22-23. In short, there is no logical equivalence between the arbitration clause in *Litton* and the health-care benefits at issue here. Absent clear textual evidence to the contrary,

contractual terms—including those regarding health-care benefits—follow the "ordinary course" and do not outlast the agreement that provides them. Respondents' accusation (at 23) that M&G has somehow "patently distorted" *Litton* is simply wrong.

In all events, ordinary contract interpretation does not treat silence as giving rise to substantive and perpetual obligations—and there is good reason for that. As set forth by M&G in its merits brief at 16-25, implying an obligation such as vested health-care benefits runs contrary to contract interpretation principles and sound policy concerns. Consequently, respondents do not even attempt a justification of *Yard-Man*'s policy rationale for placing extrinsic evidence on a level field with contract language and throwing in an inference or presumption that favors vested benefits. Those arguments lack persuasive force, even on their own terms (see *ibid.* at 18-22), and create an untenable situation for employers who are left trying to prove a negative. It is entirely consistent with traditional contract interpretation, with national labor law, and with ordinary common sense to construe silence regarding the duration of retiree health-care benefits to mean that the employer did *not*, as a matter of law, promise to provide such benefits in perpetuity.

III. The Confusion Sown By The Sixth Circuit's Approach Underscores The Need For A Uniform, Consistent Text-Based Standard

Particularly given the disarray and divergence in the lower courts, respondents' insistence that the Sixth Circuit is merely engaging in "ordinary contract interpretation" to find vested health-care benefits in virtually every collective bargaining agreement is simply not credible. Even if this Court declines to adopt a clear statement rule, it should confirm that the *text* of the collective bargaining agreement is still the best indication of the parties' intentions, as the Second and Seventh Circuits hold. Pet. Br. 30-33. A text-based approach that insists on language in an agreement that is, at a minimum, reasonably susceptible of a promise of vesting—and that requires ambiguity before extrinsic evidence can enter the picture—better comports with traditional contract interpretation, national labor law, and this Court's precedent than *Yard-Man* dressed up as "ordinary contract interpretation."

Though respondents are surely correct that intent is the touchstone of the analysis, even the case they cite (at 19) for that proposition, *Chesapeake & Ohio Canal Co.* v. *Hill*, 82 U.S. 94 (1872), makes clear that, in ascertaining intent, courts must "look carefully to the substance of the original agreement * * * in order that we may give it a fair and just construction." *Id.* at 99-100. This Court went on to say that courts should not presume or infer that parties intended to provide for certain things—intent flows

from the *text*. *Ibid.* That rule still holds force today and contractual text—no different than statutory text—must always control the inquiry. Absent an indication of vesting in the text of the agreement, none should be postulated.

The instant case highlights why such a rule is needed. Even though M&G would have prevailed in any circuit that analyzes collective bargaining agreements without a thumb on the scale in favor of vesting, the courts here were able to piece together an intent to vest from contradictory inferences and presumptions, self-serving testimony, and snippets of contractual language that, as the district court initially (and correctly) held, say absolutely nothing about the duration of retiree health-care benefits (much less promise such benefits in perpetuity). Thus the "inference" of vesting trumped not only text but also undisputed extrinsic evidence (including evidence the district court initially ruled unambiguously failed to support vesting, see Pet. App. 127-31).

A. To begin, respondents' repeated claims that it is somehow improper for the Court to consider the contrast between the absence of any durational language concerning retiree health-care benefits with the presence of such language in other parts of the agreement make little sense. For one thing, the question presented quite clearly asks whether courts, in construing collective bargaining agreements:

> [S]hould presume that silence concerning the duration of retiree health-care benefits

> means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds; or [ ] require a clear statement that health-care benefits are intended to *survive the termination of the collective bargaining agreement*, as the Third Circuit holds; or [ ] require at least some language in the agreement that can reasonably support an interpretation that health-care benefits should *continue indefinitely*, as the Second and Seventh Circuits hold.

Pet. Br. at i (emphases added). The argument about various durational clauses is thus fairly included within the question presented.

Nor is it "waived" for not being raised below. The Sixth Circuit has squarely held—as part and parcel of its *Yard-Man* analysis—that courts must disregard durational language in collective bargaining agreements unless it specifically refers to retiree benefits. See, e.g., *Cole* v. *ArvinMeritor*, 549 F.3d 1064, 1071 (6th Cir. 2008) ("General durational provisions only refer to the length of the [collective bargaining agreements] and not the period of time contemplated for retiree benefits. Absent specific durational language referring to retiree benefits themselves, courts have held that the general durational language says nothing about those retiree benefits."); *Yolton* v. *El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 580-81 (6th Cir. 2006) (same); *Yard-Man*, 716 F.2d at 1482-83. This point was made in the petition for *certiorari*. Pet. 14. There was no point in arguing to the Sixth Circuit that where, as here, an agreement is silent on

the duration of retiree health-care benefits, courts should look elsewhere in the agreement for cues—including how the parties treated the duration of other benefits. Indeed, the Sixth Circuit's rejection of any such argument only illustrates how *Yard-Man* operates selectively to allow courts to pick and choose among contractual provisions to support vesting.

Respondents acknowledge (at 12), as they must, that M&G has always maintained that the contractual language concerning "full Company contribution towards" health-care benefits is insufficient to vest benefits as a matter of law. That language—along with retirees' eligibility for health-care benefits being based on their receipt of a pension and benefits being available for surviving spouses—is the only textual hook for vesting in this case. As the district court recognized at the outset—and as respondents do not seriously dispute—those terms have nothing to say about *duration* of the benefits. Pet. App. 142-43 (noting that "full Company contribution towards" health-care benefits does not vest those benefits); see also Br. of Chamber of Commerce & Business Roundtable as *Amici Curiae* 16 ("An agreement may address both [welfare and pension] benefits together, but that is simply because a retiree may become *eligible* for both benefits at the same point in time.").

Respondents' attempt at a textual argument is defeated by understanding the link between receiving a pension and being eligible for retiree health-care benefits. The link ensures that an employee receiving retiree health-care benefits is, in fact, retired and

has not merely qualified for retirement but continues to work. The contractual language designates who is eligible for the benefit, and says nothing about how long that benefit must last.[6]

Respondents' textual argument also ignores that the agreement provides health-care benefits to workers and retirees alike—and it is undisputed that active workers' health-care benefits are not vested. In this context, then, it makes no sense to think of health-care benefits as some sort of deferred compensation. Not only is that argument undermined by the lack of a vesting schedule (as can be found with the pension benefits, see, e.g., JA 376-77), it is refuted entirely by the inconsistency in the union's position that an active worker with 95 or more points could have his retiree health-care benefits negotiated away at any time, whereas a retiree is forever vested in the same benefits.

With no contract language reasonably susceptible to an interpretation creating a perpetual entitlement to health-care benefits, respondents try to create a distraction by pointing to the credit M&G received for assuming benefits for retirees. Resp. Br. 2, 43. But the price credit simply offset a liability that M&G had to book whether or not there was an

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[6] For the same reasons, the language providing benefits to surviving spouses highlighted by respondents cannot logically be read to vest health-care benefits, either. It denotes who is eligible for the benefit, not whether the benefits are vested.

actuarial "true up" with the seller and whether or not the benefits were vested. See Financial Accounting Standard 106 (requiring companies to account for the full value of the benefits as a liability whether or not they are vested).

Respondents also insist (at 50-52) that the benefits vest because the agreement contains vesting language when referencing pension plans, but not health-care benefits, because ERISA requires the vesting of pension plans. That argument only proves M&G's point. The parties include vesting language for pension plans because they know vesting is required by statute and must be expressed in the terms of the contract. Pension vesting would never be left to the vagaries of extrinsic evidence and nebulous claims concerning the parties' intent. It would make little sense for an agreement to omit vesting language regarding a benefit not already statutorily guaranteed to vest—that thus remains subject to negotiation—if vesting were actually intended.

B. Most of all, a text-based approach is necessary to determine whether health-care benefits in a collective bargaining agreement have vested because "[t]he possibility that individual contract terms might have different meanings [in different circuits] would inevitably exert a disruptive influence upon both the negotiation and administration of collective agreements." *Local 174, Teamsters* v. *Lucas Flour Co.*, 369 U.S. 95, 103 (1962). While every circuit, including the Sixth, claims to use "ordinary contract interpretation" rules, the lower courts are "all over

the lot" when it comes to actually applying those rules. Respondents' attempt to paper over those differences is as unhelpful as it is unsuccessful.

Respondents have chosen this tactic, of course, because they cannot prevail under any standard that requires textual indication of vesting. See Pet. Br. 25-42. And this Court has recognized the common-sense principle that the weightier a commitment is, the more likely it is to be clearly indicated by the parties in their agreement—and, in all events, their agreement would not be silent on the point. See *Tarrant Reg'l Water Dist.* v. *Herrmann*, 133 S. Ct. 2120, 2133 (2013); see also Br. of ERISA Industry Committee & American Benefits Council as *Amici Curiae* 10-16 (contracting parties, like legislatures, do not "hide elephants in mouseholes").

Respondents' argument that the Sixth Circuit (and others) are merely engaged in "ordinary contract interpretation" only confirms that the problem with *Yard-Man* is not limited to its presumption or inference, but also extends to the various "rules of construction that have followed the *Yard-Man* inference." Br. of National Association of Manufacturers as *Amicus Curiae* 25. If anything, respondents' argument itself raises serious questions about whether any standard short of a clear statement rule or something very close to it can put an end to the mischief inherent in *Yard-Man*. In the absence of such a rule, disputes over retiree health-care benefits will continue to be settled in the courtroom, rather than at the bargaining table—sacrificing the uniformity and

predictability that national labor law demands. This Court should therefore reject in no uncertain terms *Yard-Man* with its imposition of extra-textual obligations based on a faulty policy rationale not even respondents seriously defend. Under any meaningfully text-based rule of construction, the agreements at issue did not vest lifetime, contribution-free health-care benefits and the Sixth Circuit's contrary judgment cannot stand.

CONCLUSION

The judgment of the Sixth Circuit should be reversed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

RECORD AND BRIEFS

Supreme Court, U.S.
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No. 13-1010

IN THE

Supreme Court of the United States

M&G POLYMERS USA, LLC, *et al.*,
Petitioners,
v.
HOBERT FREEL TACKETT, *et al.*,
Respondents.

On Writ of Certiorari to the United States Courts of Appeals for the Sixth Circuit

BRIEF OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	1
ARGUMENT	2
I. ACCEPTED PRINCIPLES OF TRADITIONAL CONTRACT LAW	4
II THE BASIC POLICY OF NATIONAL LABOR LEGISLATION	6
III. THE CLEAR STATEMENT RULE ADVOCATED BY THE COMPANY WOULD DEFEAT THE MANIFEST INTENTION OF THE PARTIES AND IS THUS CONTRARY TO FEDERAL LABOR POLICY	14
CONCLUSION	17

TABLE OF AUTHORITIES

CASES:	Page
Alabama v. North Carolina, 560 U.S. 330 (2010)	4
Allis-Chalmers Corp. v. Lueck, 471 U.S. 202 (1985)	3
Carbon Fuel Co. v. Mine Workers, 444 U.S. 212 (1979)	9, 13
Consolidated Rail Corp. v. Railway Labor Executives' Assn., 491 U.S. 299 (1989)	9, 15
H.K. Porter Co. v. NLRB, 397 U.S. 99 (1970)	6
Litton Financial Printing Div. v. NLRB, 501 U.S. 190 (1991)	16
Local Union 1395, Int'l Broth. of Electrical Workers, 797 F.2d 1027 (D.C. Cir. 1986)	8, 15
Louisville Refining Co., 4 NLRB 844 (1938)	8
Teamsters Local v. Lucas Flour Co., 369 U.S. 95 (1962)	3, 6
Mastrobuono v. Shearson Lehman Hutton, 514 U.S. 52 (1995)	4
NLRB v. American National Insurance Co., 343 U.S. 395 (1952)	15

TABLE OF AUTHORITIES—Continued

	Page
NLRB v. Insurance Agents, 361 U.S. 477 (1960)	7
S.L. Allen & Co., 1 NLRB 714 (1936)	7
Southwest Ornamental Iron Co., 38 BNA Lab. Arb. Reports 1025 (Arb. Murphy, 1962)	8
Steelworkers v. Warrior & Gulf Nav. Co., 363 U.S. 574 (1960)	7
Tymshare, Inc. v. Covell, 727 F.2d 1145 (D.C. Cir. 1984)	17
STATUTES:	
29 U.S.C. § 158(d)	4
29 U.S.C. § 185(a)	3
MISCELLANEOUS:	
FASB Statement No. 106 (Dec. 1990)	16
Fuller, *Collective Bargaining and the Arbitrator*, Fifteenth Annual Proceedings of the National Academy of Arbitrators 8 (1962)	9
Restatement (Second) of Contracts (1979)	*passim*

TABLE OF AUTHORITIES—Continued

Page

Third Annual Report of the NLRB (1938).... 8

BRIEF OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

The American Federation of Labor and Congress of Industrial Organizations is a federation of 56 national and international labor organizations with a total membership of 12.5 million working men and women.[1] This case addresses the proper interpretation of provisions in collective bargaining agreements providing health insurance coverage to eligible retirees. Industrial unions affiliated with the AFL-CIO often negotiate collective bargaining agreements containing such provisions.

SUMMARY OF ARGUMENT

This case raises the issue of the interpretative standard that should be applied in determining the effect of a collectively bargained retiree health insurance provision. This issue is governed by the federal common law of contracts under Section 301 of the Labor Management Relations Act, which is developed from both accepted principles of traditional contract law and the basic policy of national labor legislation.

A basic principle of traditional contract law is that

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[1] Counsel for the petitioner and counsel for the respondents have filed letters with the Court consenting generally to the filing of all *amicus* briefs. No counsel for a party authored this brief *amicus curiae* in whole or in part, and no person or entity, other than the *amicus*, made a monetary contribution to the preparation or submission of this brief.

the words of a contract should be interpreted in accord with the parties' mutual understanding of the words' meaning. Accordingly, the common law treats evidence of actions and statements by the parties demonstrating their mutual understanding of their contractual terms as relevant to the task of interpretation.

The basic policy of national labor legislation is to allow the parties to a collective bargaining agreement to define their contractual relationship for themselves. That policy is furthered by interpreting collective bargaining agreements in accord with the parties' mutual understanding of their agreement. Therefore, the common law rules regarding contract interpretation are in complete accord with the basic policy of national labor legislation. The nature of the collective bargaining relationship is such that the parties will frequently have the occasion to make statements and engage in actions that tend to demonstrate their mutual understanding of the terms of their agreement. Evidence of such statements and actions is highly relevant to the proper interpretation of collectively bargained contract terms.

The interpretative rule advocated by the Company is contrary to both traditional contract law and to federal labor policy. The Company's rule would impose a particular result with regard to the duration of a retiree health insurance provision regardless of the parties' demonstrated mutual understanding as to the provision's duration.

ARGUMENT

The legal issue presented by this case is the proper standard to be applied in determining whether a pro-

vision in a collective bargaining agreement creating a retirement benefit of a full employer contribution toward the cost of health insurance coverage – provided to those retirees who have met the contractual age and years of service requirements – continues in effect beyond the general termination date of the agreement.

The proper answer to this legal question must be drawn from the "body of federal common law" developed under Section 301 of the Labor Management Relations Act "to address disputes arising out of labor contracts." *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 209 (1985). *See* 29 U.S.C. § 185(a). The federal common law of contracts under § 301 is derived from both "accepted principles of traditional contract law" and "the basic policy of national labor legislation." *Teamsters Local v. Lucas Flour Co.*, 369 U.S. 95, 105 (1962).

The accepted principles of traditional contract law and the basic policy of national labor legislation both point in the same direction with regard to the appropriate standard for interpreting the terms of a collective bargaining agreement. When it comes to interpreting the words of a contract, the common law of contracts makes the parties' mutual understanding of the meaning of their chosen contractual words determinative. To achieve that end, the common law treats the parties' statements and actions demonstrating their mutual understanding of the words of their contract as relevant to the interpretation of those words. That approach to contract interpretation advances the federal labor policy of allowing the parties to a collective bargaining agreement to define their contractual relationship for themselves with minimal

government interference. By contrast, the "clear statement rule" advanced by the Company – requiring a clear, express contractual statement that retiree health insurance coverage continues in force after the general expiration date of the collective bargaining agreement – would present an unacceptable risk of defeating the parties' mutual understanding of their agreement and is thus contrary to both the accepted principles of traditional contract law and the basic policy of national labor legislation.

I. ACCEPTED PRINCIPLES OF TRADITIONAL CONTRACT LAW.

The National Labor Relations Act requires "the execution of a written contract incorporating any agreement reached [during collective bargaining] if requested by either party." 29 U.S.C. § 158(d). Thus, collective bargaining agreements generally meet the common law definition of an "integrated agreement" as "a writing . . . constituting a final expression of one or more terms of an agreement." *Restatement (Second) of Contracts* § 209(1) (1979). The common law regarding the interpretation of an integrated agreement is succinctly summarized in § 212 of the *Restatement (Second) of Contracts*. *See, e.g., Alabama v. North Carolina*, 560 U.S. 330, 346 (2010) (relying on the *Restatement (Second) of Contracts* as stating the common law interpretative rules); *Mastrobuono v. Shearson Lehman Hutton*, 514 U.S. 52, 59 (1995) (same).

Restatement § 212(1) provides that the "interpretation of an integrated agreement is directed to the meaning of the terms of the writing . . . in the light of the circumstances, in accordance with the rules stated

in this Chapter." The first and most basic of the "rules in aid of interpretation" stated in that Chapter of the *Restatement* is that "[w]ords and other conduct are interpreted in the light of all the circumstances, and if the principal purpose of the parties is ascertainable it is given great weight." *Restatement* § 202(1). This interpretative rule reflects the common law's premise that "[i]nterpretation of contracts deals with the meaning given to language and other conduct by the parties rather than with meanings established by law." *Id.* at § 212, comment a. Thus, "[t]he objective of interpretation in the general law of contracts is to carry out the understanding of the parties rather than to impose obligations on them contrary to their understanding." *Id.* § 201 comment c.

To ensure that "the operative meaning [of the parties' agreement] is found in the[ir] transaction and its context rather than in the law or in the usages of people other than the parties," *Restatement* § 212, comment a, the common law provides that:

> "Any determination of meaning or ambiguity should only be made in the light of the relevant evidence of the situation and relations of the parties, the subject matter of the transaction, preliminary negotiations and statements made therein, usages of trade, and the course of dealing between the parties. But after the transaction has been shown in all its length and breadth, the words of an integrated agreement remain the most important evidence of intention." *Id.* § 212, comment b (internal citations omitted).

The heart of the matter is that "[w]here the parties have attached the same meaning to a promise or

agreement or a term thereof, it is interpreted in accordance with that meaning." *Restatement* § 201(1). Thus, actions taken and statements made during both the "preliminary negotiations" and the parties' "course of dealing" under the agreement indicating their mutual understanding of the contractual terms are highly relevant to the interpretation of their agreement.

As we show next, the foregoing rules apply fully to the interpretation of collective bargaining agreements under LMRA § 301, not only because they are the "accepted principles of traditional contract law" but also because they further "the basic policy of national labor legislation." *Lucas Flour*, 369 U.S. at 105.

II. THE BASIC POLICY OF NATIONAL LABOR LEGISLATION

A. "The object of th[e National Labor Relations] Act was not to allow governmental regulation of the terms and conditions of employment, but rather to ensure that employers and their employees could work together to establish mutually satisfactory conditions." *H.K. Porter Co. v. NLRB*, 397 U.S. 99, 103 (1970). Accordingly, "the fundamental premise on which the Act is based [is] private bargaining under governmental supervision of the procedure alone, without any official compulsion over the actual terms of the contract." *Id.* at 108.

The National Labor Relations Act "impose[s] a mutual duty upon the parties to confer in good faith with a desire to reach agreement, in the belief that . . . [d]iscussion conducted under that standard of good faith may narrow the issues, making the real demands of the parties clearer to each other, and perhaps to them-

selves, and may encourage an attitude of settlement through give and take." *NLRB v. Insurance Agents*, 361 U.S. 477, 488 (1960). "Interchange of ideas, communication of facts peculiarly within the knowledge of either party, personal persuasion and the opportunity to modify demands in accordance with the total situation thus revealed at the conference is the essence of the bargaining process" mandated by the National Labor Relations Act. *S.L. Allen & Co.*, 1 NLRB 714, 728 (1936).

At the same time, "[t]he presence of economic weapons in reserve, and their actual exercise on occasion by the parties, is part and parcel of the system." *Insurance Agents*, 361 U.S. at 489. And, it is precisely the fact that labor negotiations can devolve into "a brute contest of economic power," *ibid.*, that motivated Congress to require the parties engage in good faith bargaining with the aim of reaching agreement:

> "When most parties enter into contractual relationship they do so voluntarily, in the sense that there is no real compulsion to deal with one another, as opposed to dealing with other parties. This is not true of the labor agreement. The choice is generally not between entering or refusing to enter into a relationship, for that in all probability preexists the negotiations. Rather, it is between having that relationship governed by an agreed-upon rule of law or leaving each and every matter subject to a temporary resolution dependent solely upon the relative strength, at any given moment, of the contending forces." *Steelworkers v. Warrior & Gulf Nav. Co.*, 363 U.S. 574, 580 (1960).

Given the nature of the employment relationship and the federal regulation of the collective bargaining process, the National Labor Relations Board has long understood that any agreement must be understood as emerging from the bargaining process:

> "The final attainment of an understanding and the signing of the contract embodying the fruits of this understanding are part and parcel of the process of collective bargaining. The contract or agreement is part of and the culmination of the successful negotiations, and not a segment separate from the negotiations which have preceded it." *Third Annual Report of the NLRB* 102-03 (1938), quoting *Louisville Refining Co.*, 4 NLRB 844, 860 (1938).

Against that background, it is not "appropriate to interpret collective bargaining agreements in a vacuum," *Local Union 1395, Int'l Broth. of Electrical Workers*, 797 F.2d 1027, 1033 (D.C. Cir. 1986), because "the words of the contract do not stand alone; they do not exist in a vacuum," *Southwest Ornamental Iron Co.*, 38 BNA Lab. Arb. Reports 1025, 1027 (Arb. Murphy, 1962):

> "Behind them stand the industrial practices to which the words of the contract have reference, the bargaining history of the parties over a period of years, and the understanding and intention of the parties when they executed their current contract." *Ibid.*

As we have seen, the common law of contracts treats such manifestations of mutual understanding as relevant to the interpretation of contractual terms, for "[t]he objective of interpretation in the general law

of contracts is to carry out the understanding of the parties rather than to impose obligations on them contrary to their understanding." *Restatement* § 201, comment c. Precisely because the federal labor laws share this objective, it is well-established that "bargaining history," *Carbon Fuel Co. v. Mine Workers*, 444 U.S. 212, 219 (1979), and "the parties' 'practice, usage and custom,'" *Consolidated Rail Corp. v. Railway Labor Executives*, 491 U.S. 299, 311 (1989), are properly considered in determining the parties' mutual understanding of the meaning of the terms in their collective bargaining agreement.

So that we are not misunderstood, we emphasize that extrinsic evidence is relevant *only* if it tends to demonstrate the parties' *mutual* understanding of the words in their agreement. This is so, because "the [*only*] intention of a party that is relevant to the formation of a contract is the intention *manifested* by him rather than any different *undisclosed* intention." *Restatement* § 200, comment b (emphasis added). *See id.* § 212, comment a. Thus, a party should *not* be allowed to "testify to what *he* meant by a phrase in the agreement," unless he can show that "he communicated his interpretation to the other party" or can otherwise "show that the other party ought reasonably to have put the same interpretation on the phrase." Fuller, *Collective Bargaining and the Arbitrator*, Fifteenth Annual Proceedings of the National Academy of Arbitrators 8, 12 (1962) (emphasis in original). By their very nature, however, bargaining history – which will concern what the parties *communicate* to each other during negotiations – and past practice – which will concern what the parties have *said and done* in applying their agreement – will constitute

relevant evidence of how the parties have *manifested* their *mutual* understanding of the contract terms.

B. To make the foregoing legal points more concrete, we end this discussion of the proper approach to interpreting collective bargaining agreements by counterpoising two hypothetical collective bargaining situations that demonstrate how consideration of the negotiations leading to an agreement and the parties' practical construction of the agreed-upon terms can be crucial to the proper interpretation of a collective bargaining agreement.

Both hypotheticals concern a clause that provides: "Employees who retire from active employment with 35 years of continuous service will receive a full Company contribution towards the costs of health insurance for themselves and for their surviving dependents." In both hypotheticals, the clause is included in the parties' initial collective bargaining agreement as a result of a union proposal, which is ultimately accepted by the employer. In both hypotheticals, the clause is later carried over from one collective bargaining agreement to another without any change in its wording.

First Hypothetical. The employer responds to the union's proposal by asking whether the proposal is intended to create a retirement benefit that would continue to cover retired employees throughout their retirement or to merely extend to retired employees whatever insurance coverage is currently available under an existing contract to active employees. When the union explains that the proposal is intended to be a retirement benefit that would continue in effect for

the life of the retiree and his or her surviving dependents, the employer responds by proposing the addition of an express limitation to the effect that "the promise of a full Company contribution does not extend beyond the termination date of this agreement." The difference over the duration of the retiree health insurance benefit results in a strike, which concludes when the employer agrees to the union's original proposal without the employer's proposed limitation.

After the expiration of the initial agreement, negotiations for a successor collective bargaining agreement come to an impasse over the employer's proposal to eliminate health insurance coverage generally. The employer implements that proposal by refusing to pay for the health insurance coverage of active employees but continues to pay for retiree health insurance coverage, explaining to the retirees that they have a contractual right to the continued payments. Thereafter, the parties reach an agreement containing the same health insurance provisions as the first agreement, including the provision for retiree health insurance coverage. In subsequent agreements, the insurance provisions are included without further dispute or discussion.

Second Hypothetical. The employer responds to the union's proposal by asking whether the proposal is intended to create a retirement benefit that would continue to cover retired employees throughout their retirement or to merely extend to retired employees whatever insurance coverage is currently available under an existing contract to active employees. When the union explains that the proposal would merely ex-

tend to retired employees whatever insurance coverage is currently available under an existing contract to active employees, the employer agrees to the proposal on the express understanding that the commitment to pay for retiree health insurance coverage will expire with the collective bargaining agreement.

After the expiration of the initial agreement, negotiations for a successor collective bargaining agreement come to an impasse over the employer's proposal to eliminate health insurance coverage generally. The employer implements that proposal by refusing to pay for health insurance coverage for either active employees or retirees. The union accedes to the employer's action, explaining to the employees that the employer's contractual obligation to pay for health insurance coverage for both active employees and retirees had expired with the collective bargaining agreement. Thereafter, the parties reach an agreement containing the same health insurance provisions as the first agreement, including the provision for retiree health insurance coverage. In subsequent agreements, the insurance provisions are included without further dispute or discussion.

Both hypotheticals involve precisely the same retiree health insurance provision. But in the first hypothetical the parties' initial negotiations and subsequent interpretation of that provision conclusively demonstrate that it was intended to remain in effect beyond the expiration date of the collective bargaining agreement. While in the second hypothetical the parties' initial negotiations and subsequent interpretation of that provision conclusively demonstrate that it was intended to expire with the rest of the collective bargaining agreement.

The point of these hypotheticals is simply that reading a collectively bargained provision without regard to the relevant evidence of the parties' actions and statements indicating a mutual understanding of its meaning creates an unacceptable risk of "substitut[ing] a different resolution," *Carbon Fuel*, 444 U.S. at 219, for that reached by the parties.

* * *

In sum, the basic policy of national labor legislation is best served by applying the accepted principles of traditional contract law, which require that "[a]ny determination of [a term's] meaning . . . should only be made in the light of the relevant evidence of the situation and relations of the parties, the subject matter of the transaction, preliminary negotiations and statements made therein, . . . and the course of dealing between the parties." *Restatement* § 212, comment b. Of course, "*after* the transaction has been shown *in all its length and breadth*, the words of [the collective bargaining] agreement [will] remain the most important evidence of intention." *Ibid.* (emphasis added).[2] But to interpret "the words" without considering "the transaction . . . in all its length and breadth" risks imposing on the parties a very different agreement than the one they negotiated.

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[2] Whether the words of the agreement are susceptible to an asserted reading is a question of law to be decided by the trial court and is subject to plenary review by an appellate court. *Id.* § 212, comment d.

III. THE CLEAR STATEMENT RULE ADVOCATED BY THE COMPANY WOULD DEFEAT THE MANIFEST INTENTION OF THE PARTIES AND IS THUS CONTRARY TO FEDERAL LABOR POLICY.

The Company argues that a special interpretative rule should apply to contracts regarding employer payment of retiree health insurance premiums. The Company articulates two – admittedly "similar" – variations of the special interpretative rule it would apply to retiree health insurance agreements, which it denominates as "[t]he clear statement rule" or "the affirmative-textual-indication rule." Pet. Br. 33. The first variant would require "a clear, express statement that the parties intended for health-care benefits to vest" if the benefits are "to extend beyond the term of the agreement." *Id.* at 25. The second variant would require contractual "language that affirmatively operates to create the promise of vesting." *Id.* at 30 (citation and quotation marks omitted).

The sum and substance of the Company's argument is that the common law of collective bargaining agreements under § 301 should include an interpretative rule to the effect that retiree health insurance provisions expire at the general expiration date of the agreement unless the parties expressly provide that the provision continues in force beyond that date. In other words, regardless of any manifested mutual understanding of the parties regarding the duration of a retiree health insurance provision, the provision must be conclusively presumed to expire on the expiration date of the general agreement.

"[F]ederal labor policy [would be] threatened by

the interposition of [such] artificial rules of construction upon the parties' mutual intent." *Local Union 1395*, 797 F.2d at 1031. This is so, because "[a] grudging or stilted interpretation of collective bargaining agreements tends to encroach upon the fundamental national policy favoring the ordering of the employer-employee relationship by voluntary bargaining rather than governmental fiat." *Id.* at 1031-32. The adoption of a special interpretative rule under § 301 that "would subject to especially strict scrutiny . . . contractual claims" regarding the duration of retiree health insurance benefits "would be to limit the enforceability of such contract terms" and thus would "impermissibly . . . 'pass upon the desirability of the substantive terms of labor agreements,' by affording [such] terms a less favored status." *Consolidated Rail*, 491 U.S. at 309, quoting *NLRB v. American National Insurance Co.*, 343 U.S. 395, 408-09 (1952).

Consideration of the first hypothetical discussed in the prior section of this brief demonstrates how the Company's "clear statement rule" – under which a retiree health insurance provision terminates with the general agreement unless there is an express statement that the provision continues in effect beyond the general expiration date of the agreement – could substitute a different resolution of the duration issue than that reached by the parties. The Company's rule would require that the retiree health insurance provision in the hypothetical expire with the rest of the collective bargaining agreement, regardless of the employer having acceded to the union's demand that the provision continue in force beyond the agreement's expiration and regardless of the employer's statements and actions demonstrating its understand-

ing that the provision from the expired collective bargaining agreement continued in force even though there was no current collective bargaining agreement. In those circumstances, application of the "clear statement rule" would frustrate the parties' mutual understanding of the retiree health insurance provision they had negotiated.

It would be particularly perverse to conclusively presume that retiree health insurance terminates with the expiration of the collective bargaining agreement, since a retirement benefit of that sort is most naturally "understood as a form of deferred compensation." *Litton Financial Printing Div. v. NLRB*, 501 U.S. 190, 210 (1991). *See Restatement* § 212, comment b ("subject matter of the transaction" is relevant to interpretation). As the Financial Accounting Standards Board has explained, where, "[i]n exchange for services provided by the employee, the employer promises to provide, in addition to current wages and other current and deferred benefits (such as a pension), health care and other welfare benefits during the employee's retirement period," those "[p]ostretirement benefits are not gratuities but instead are part of an employee's compensation for services rendered." FASB Statement No. 106, ¶ 146, p. 47 (Dec. 1990). Benefits of this sort that are "in the nature of 'accrued' or 'vested' rights, earned by employees during the term of the contract," *Litton Financial Printing*, 501 U.S. at 203 (quotation marks and citation omitted), "will, as a general rule, survive termination of the agreement," *id.* at 207. The contrary reading, which would allow the employer to unilaterally decide not to pay the agreed upon deferred compensation for the services rendered under the agreement would not "honor[] the

reasonable expectations created by the autonomous expression of the contracting parties." *Tymshare, Inc. v. Covell*, 727 F.2d 1145, 1152 (D.C. Cir. 1984).

In short, the special interpretative rule advocated by the Company is contrary to "the fundamental premise on which the [National Labor Relations] Act is based – private bargaining under governmental supervision of the procedure alone, without any official compulsion over the actual terms of the contract." *H.K. Porter*, 397 U.S. at 108.

CONCLUSION

The decision of the court of appeals should be affirmed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

RECORD AND BRIEFS

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v.

HOBERT FREEL TACKETT, ET AL., RESPONDENTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND THE BUSINESS ROUNDTABLE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether, when construing collective bargaining agreements in Labor Management Relations Act cases, courts should presume that silence concerning the duration of retiree healthcare benefits means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds; or should require a clear statement that healthcare benefits are intended to survive the termination of the collective bargaining agreement, as the Third Circuit holds; or should require at least some language in the agreement that can reasonably support an interpretation that healthcare benefits should continue indefinitely, as the Second and Seventh Circuits hold.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES iv

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 5

I. Benefit obligations do not outlast the collective bargaining agreement in which they are found, unless the agreement itself affirmatively provides otherwise. 5

A. Under *Litton*, absent agreement to the contrary, contractual obligations cease with the collective bargaining agreement of which they are a part. 5

B. Presuming that benefits vest based on silence ignores and distorts the collective bargaining process. 8

C. The *Yard-Man* decision fundamentally misinterprets *Pittsburgh Plate Glass* and ignores ERISA's vesting rules. 14

II. Finding vested benefits absent affirmative agreement would impose massive retroactive liability on employers and work to the detriment of everyone involved. 17

A. Endorsing *Yard-Man* would lead to massive and unexpected retroactive costs for employers. 17

B. Nearly every party to a collective bargaining agreement suffers from *Yard-Man*'s presumption of vesting..... 20

CONCLUSION 24

TABLE OF AUTHORITIES

Page(s)

CASES

Allied Chem. & Alkali Workers v. *Pittsburgh Plate Glass Co.*,
404 U.S. 181 (1971) 3, 9, 11, 14, 15

Am. Fed. of Grain Millers, AFL-CIO v. *Int'l Multifoods Corp.*,
116 F.3d 976 (2d Cir. 1997) 7

Anderson v. *Alpha Portland Indus., Inc.*,
836 F.2d 1512 (8th Cir. 1988) 8

Auciello Iron Works, Inc. v. *NLRB*,
517 U.S. 781 (1996) 6

Barnett v. *Ameren Corp.*,
436 F.3d 830 (7th Cir. 2006) 7

Curtiss-Wright Corp. v. *Schoonejongen*,
514 U.S. 73 (1995) 9, 13

Golden v. *Kelsey-Hayes Co.*,
73 F.3d 648 (6th Cir. 1996) 16, 22

H.K. Porter Co., Inc. v. *NLRB*,
397 U.S. 99 (1970) 6, 10

Int'l Union, UAW v. *Skinner Engine Co.*,
188 F.3d 130 (3d Cir. 1999) 16

Int'l Union, UAW v. *Yard-Man, Inc.*,
716 F.2d 1476 (6th Cir. 1983) ..... *passim*

Litton Financial Printing Division v. *NLRB*,
501 U.S. 190 (1991) ..... *passim*

Maurer v. *Joy Techs., Inc.*,
212 F.3d 907 (6th Cir. 2000) 7, 13

McCoy v. *Meridian Auto. Sys., Inc.*,
390 F.3d 417 (6th Cir. 2004) 15

Moore v. *Metro. Life Ins. Co.*,
856 F.2d 488 (2d Cir. 1988) 16

NLRB v. *Am. Nat'l Ins. Co.*,
343 U.S. 395 (1952) 9, 10, 11

NLRB v. *Ins. Agents' Int'l Union, AFL-CIO*,
361 U.S. 477 (1960) 6

NLRB v. *Jones & Laughlin Steel Corp.*,
301 U.S. 1 (1937) 6

Noe v. *PolyOne Corp.*,
520 F.3d 548 (6th Cir. 2008) 7, 13, 15

Reese v. *CNH Am. LLC*,
574 F.3d 315 (6th Cir. 2009) 12, 22

Reese v. *CNH Am. LLC*,
694 F.3d 681 (6th Cir. 2012) 22

Smith v. *Evening News Ass'n*,
371 U.S. 195 (1962) 9

Textile Workers Union of Am. v. *Lincoln Mills of Alabama*,
353 U.S. 448 (1957) 9

United Steel, Paper & Forestry, Rubber, Mfg. Energy, Allied Indus. & Serv. Workers Int'l Union, AFL-CIO-CLC v. *Kelsey-Hayes Co.*,
750 F.3d 546 (6th Cir. 2014) 18, 22, 23

Wood v. *Detroit Diesel Corp.*,
607 F.3d 427 (6th Cir. 2010) 20

STATUTES

29 U.S.C. § 158(a)(3) 9

29 U.S.C. § 158(b)(5) 9

29 U.S.C. § 158(d) 6

29 U.S.C. § 1051 ..... 12, 16

Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 ..... 1, 2, 3, 4, 16

Labor-Management Relations Act, 29 U.S.C. § 185a 4, 9, 11, 15

National Labor Relations Act, 29 U.S.C. §§ 151-169 ..... 4, 6, 9, 10, 13

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United Steelworkers: Summary, OpenSecrets, https://www.opensecrets.org/orgs/summary.php?id=D000000102&cycle=A 11

INTEREST OF *AMICI CURIAE*[1]

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million companies and organizations of every size, in every industry sector, from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases that raise issues of concern to the nation's business community.

The Business Roundtable is an association of chief executive officers who collectively manage more than 14 million employees and $6 trillion in annual revenues. The association was founded on the belief that businesses should play an active and effective role in the formation of public policy. It participates in litigation as *amicus curiae* in a variety of contexts where important business interests are at stake.

The members of both *amici* have a substantial interest in the proper interpretation of collective bargaining agreements regarding the provision of healthcare benefits to employees, retired employees, and their dependents, through employee welfare benefit plans regulated by the Employee Retirement In-

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[1] The parties consented to this filing. Their letters of consent are on file with the Clerk. Pursuant to this Court's Rule 37.6, *amici* state that no counsel for any party authored this brief in whole or in part, and that no person or entity, other than *amici*, their members, and their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

come Security Act, 29 U.S.C. §§ 1001-1461 (ERISA). As explained below, by requiring a company to provide unalterable, or "vested," healthcare benefits for their retired employees (and their dependents), the Sixth Circuit's decision below threatens to impose enormous and unforeseen retroactive funding liabilities on American companies. Employers may be forced to reduce their active work forces, divert funds from research and development, or absorb these unexpected and substantial costs by raising prices for their products and services. Some employers, particularly those in industries with significant retiree populations, already have been driven to the brink of bankruptcy by the Sixth Circuit's approach to interpreting collective bargaining agreements that provide retiree healthcare benefits. *Amici* therefore submit this brief to apprise this Court of the potential consequences for American business if the Sixth Circuit's judgment is affirmed.

SUMMARY OF ARGUMENT

The Sixth Circuit held that the parties' collective bargaining agreements granted M&G Polymers USA's retirees a vested right to lifetime, contribution-free healthcare benefits. It reached this conclusion even though the agreements, among other things: (1) included no promise of vested benefits; (2) contained a durational clause expressly denoting each agreement's expiration date, with no carve-out or separate durational provision addressed to retiree benefits; and (3) were, as a matter of course, accompanied by "cap letters" that limited the employer's annual contribution to retiree healthcare costs. The Sixth Circuit was able to reach this outcome only by relying on its so-called *Yard-Man* presumption, see *International Union, UAW* v. *Yard-Man, Inc.*, 716 F.2d 1476 (6th

Cir. 1983), which infers that an employer agreed to provide perpetual, unalterable benefits to retirees and their dependents based *not* on what an agreement says, but rather on the supposed meaning of its silence.

The Sixth Circuit's interpretive approach misreads silence as reflecting an affirmative agreement by the parties. Silence is not how sophisticated parties memorialize an agreement to provide costly, immutable healthcare benefits. This Court recognized as much in *Litton Financial Printing Division* v. *NLRB*, 501 U.S. 190 (1991), ruling that "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement" unless the "collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration." *Id.* at 207. By recognizing that parties to a collective bargaining agreement will rarely, if ever, agree to provide a substantial benefit, in perpetuity, without doing so *expressly*, the rule in *Litton* best reflects the parties' likely intent. It is also a clear rule that produces consistent results.

The *Yard-Man* presumption, on the other hand, not only conflicts with both *Litton* and the realities of collective bargaining, it also distorts and imbalances the collective bargaining process, misconstrues this Court's holding in *Allied Chemical and Alkali Workers* v. *Pittsburgh Plate Glass Co.*, 404 U.S. 181 (1971), and flies in the face of Congress's decision to make employee-pension plans and employee welfare benefit plans under ERISA subject to different vesting rules. By rejecting *Yard-Man* in no uncertain terms, this Court would make clear that every provision in a collective bargaining agreement—including those concerning retiree welfare benefits—should be interpret-

ed consistent with established federal labor policy under the National Labor Relations Act, 29 U.S.C. §§ 151-169 (NLRA) and the Labor-Management Relations Act, 29 U.S.C. § 185a (LMRA), as well as ERISA, this Court's precedents interpreting those laws, and traditional methods of contract interpretation.

Finally, the Sixth Circuit's presumption of vesting should also be rejected because it harms all of the parties involved. The Sixth Circuit's approach imposes unpredictable and substantial labor costs on American companies, weakening their international competitiveness and adversely affecting their employees, retirees, and customers. Healthcare costs keep rising, and the cost of providing healthcare benefits only increases as individuals age. At the same time, as life expectancy increases, the retiree population grows both in absolute numbers and in proportion to active employees. A judicially created obligation to provide retirees with irreducible lifelong benefits thus forces employers to bear substantial, retroactive, and unbargained-for costs. This hurts employers, puts downward pressure on active employees' wages and financial opportunities, and even harms retirees themselves, as it precludes cost-efficient access to the newest and best medical care.

These demographic and societal trends underscore the implausibility of the Sixth Circuit's presumption that employers would silently agree to provide vested, lifelong healthcare benefits for retirees and their dependents. Faithfulness to the *Litton* rule as the starting point for the relevant contractual analysis would properly limit employers' retiree obligations to those voluntarily undertaken, thereby protecting em-

ployers, employees, retirees, and the American economy as a whole against all of these problems.

ARGUMENT

I. Benefit obligations do not outlast the collective bargaining agreement in which they are found, unless the agreement itself affirmatively provides otherwise.

As urged by Petitioners, this Court should reaffirm that the clear-statement rule set forth in *Litton* governs the interpretation of retiree welfare benefit provisions. That rule aligns with the reality that employers agreeing to vested healthcare benefits for retirees would only do so expressly. It also provides a clear rule that will produce consistent and predictable results.

At a minimum, this Court should reject the Sixth Circuit's use of contractual silence to compel fixed welfare benefits for the duration of retirees' lives, and clarify that an obligation such as this must be reflected in the affirmative terms of the agreement—not through silence. Failing such affirmative agreement, retiree healthcare provisions must be understood to expire with the agreement of which they are a part.

A. Under *Litton*, absent agreement to the contrary, contractual obligations cease with the collective bargaining agreement of which they are a part.

As a general rule of labor law, when a collective bargaining agreement expires, so too do both sides' obligations thereunder. As this Court said in *Litton*: "contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement" unless the "collective-bargaining agreement

provides in explicit terms that certain benefits continue after the agreement's expiration." 501 U.S. at 207. This Court should reaffirm that principle here.

1. The collective bargaining process mandates and facilitates good-faith meetings to establish the terms of an employment relationship by mutual agreement. 29 U.S.C. § 158(d); *NLRB* v. *Ins. Agents' Int'l Union, AFL-CIO*, 361 U.S. 477, 488 (1960) (collective bargaining "encourage[s] an attitude of settlement through give and take"). Among its other purposes, the NLRA was enacted to "achieve stability in collective-bargaining relationships." *Auciello Iron Works, Inc.* v. *NLRB*, 517 U.S. 781, 786 (1996) (citations omitted). That policy reflects, at its core, a recognition that permitting the parties to negotiate their own contracts *without judicial interference* will maximize the potential for effective and stable labor relations. See *H.K. Porter Co., Inc.* v. *NLRB*, 397 U.S. 99, 103 (1970) ("The object of [the NLRA] was * * * to ensure that employers and their employees could work together to establish mutually satisfactory conditions.").

Because collective bargaining is driven by mutual give and take, no obligation may arise under a collective bargaining agreement absent a memorialized meeting of the minds; the NLRA "does not compel either party to agree to a proposal or require the making of a concession." *Id.* at 106; accord *NLRB* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 45 (1937).

2. The Sixth Circuit's so-called *Yard-Man* presumption, however, is wholly inconsistent with this scheme. In this case, the Sixth Circuit applied *Yard-Man* to conclude that the company's commitment to make a "full * * * contribution" to retiree benefit costs

would be rendered "illusory" if the company could "unilaterally change the level of contribution" after the agreement's expiration. Pet. App. 11. But the same could be said of any other obligation that expires with the agreement. Such an obligation is not "illusory"; it is binding and enforceable *only during the term of the parties' agreement.*

Moreover, the Sixth Circuit ignored the collective bargaining agreement's "general" durational clause. Pet. App. 28 (explaining that the collective bargaining agreements "typically" lasted about three years). Under its *Yard-Man* presumption, although every other provision in an agreement is controlled by a general durational clause, the Sixth Circuit has decided that retiree welfare benefits are not. See, *e.g.*, *Noe* v. *PolyOne Corp.*, 520 F.3d 548, 554 (6th Cir. 2008); *Maurer* v. *Joy Techs., Inc.*, 212 F.3d 907, 917-918 (6th Cir. 2000). This approach is neither warranted nor logical.

Indeed, most courts have disagreed with the Sixth Circuit and recognized that a party's obligations under an agreement are controlled by the agreement's general durational clause absent some textual indication to the contrary. *E.g.*, *Barnett* v. *Ameren Corp.*, 436 F.3d 830, 832-833 (7th Cir. 2006) ("If [an agreement] or other governing document provides for health-care benefits for retirees, but is silent on the issue of whether or not those benefits exceed the life of the agreement, then in this circuit the presumption is that the benefits expire with the agreement.") (citations omitted); *Am. Fed. of Grain Millers, AFL-CIO* v. *Int'l Multifoods Corp.*, 116 F.3d 976, 981 (2d Cir. 1997) (stating that language guaranteeing a level of benefits "during the term of th[e] agreement" created a benefit obligation running only for the fixed period

of the labor contract and no longer); *Anderson* v. *Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1519 (8th Cir. 1988) ("It would render the durational clauses nugatory to hold that benefits continue for life even though the agreement which provides the benefits expires on a certain date.").

This Court too should reject the Sixth Circuit's *Yard-Man* presumption and require, consistent with *Litton*, that an employer's obligation to provide retiree healthcare benefits ends with the collective bargaining agreement in which the benefits are provided, unless the agreement explicitly provides otherwise.

B. Presuming that benefits vest based on silence ignores and distorts the collective bargaining process.

At a minimum, an agreement to provide vested retiree healthcare benefits for life may not be inferred from silence. This is the fundamental problem with the *Yard-Man* presumption: it places an outcome-determinative significance on silence, inferring regardless of the facts of a particular case that the parties "likely intended [retiree welfare] benefits to continue as long as the beneficiary remains a retiree." *Yard-Man*, 716 F.2d at 1482. This approach effectively adds terms to the parties' agreement by judicial fiat, which is contrary to established principles of federal law and labor policy. It also interferes with the bilateral bargaining scheme established by the federal labor laws. Indeed, far from reflecting the reality of collective bargaining, a vesting presumption ignores and distorts the collective bargaining process.

1. This Court has made clear that no court "directly or indirectly * * * sit[s] in judgment upon the

substantive terms of collective bargaining agreements." *NLRB* v. *Am. Nat'l Ins. Co.*, 343 U.S. 395, 404 (1952). Similarly, this Court has long recognized that, when interpreting a collective bargaining agreement, traditional rules of contract interpretation must be applied in light of basic principles of the federal labor scheme. See *Textile Workers Union of Am.* v. *Lincoln Mills of Alabama*, 353 U.S. 448, 456 (1957) ("the substantive law to apply in suits under [Section 301] is federal law, which the courts must fashion from the policy of our national labor laws"); see also *Smith* v. *Evening News Ass'n*, 371 U.S. 195, 200 (1962) (using as a touchstone for interpreting Section 301 the "congressional policy of having the administration of collective bargaining contracts accomplished under a uniform body of federal substantive law").

To be sure, the NLRA requires employers and unions to bargain with respect to a number of mandatory subjects—but retiree benefits are not among them. 29 U.S.C. §§ 158(a)(3) and 158(b)(5); *Pittsburgh Plate Glass*, 404 U.S. at 181 n.20 (1971). As a result, a collective bargaining agreement can *wholly exclude* retiree welfare benefits, yet be in full compliance with federal law. Thus, an employer's obligations to retirees are—and must be—defined solely by the agreement. And even *if* retiree healthcare benefits are contemplated by the agreement, once that contract expires, employers are "generally free * * * for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995).

This is what silence—a lack of agreement—must be understood to leave in place. In the event the parties to a collective bargaining agreement actually in-

tend to vest retiree healthcare benefits, they must do so affirmatively. Otherwise—that is, absent a memorialized undertaking to provide unalterable benefits in perpetuity—retiree welfare provisions expire with the rest of the parties' agreement.

As this case shows, the Sixth Circuit's *Yard-Man* presumption stands in opposition to all of this. The court below inferred that retiree benefits are fixed for the duration of the retirees' lives, despite the fact that no language in the agreement promised forever unalterable benefits, each agreement had a general durational clause with no exception or carve-out for retiree benefits, the employer never relinquished its right to modify or even cease providing retiree benefits, and retiree benefits under prior agreements were capped by side agreements. In this way, the court below effectively imposed a substantive term on the parties, in direct violation of federal labor law. See *Am. Nat'l Ins. Co.*, 343 U.S. at 404. This unwarranted result directly contravenes federal labor policy.

2. A further problem is the impact of the Sixth Circuit's flawed approach on the collective bargaining process itself. "It is implicit in the entire structure of the [NLRA] that the Board acts to oversee and referee the process of collective bargaining, leaving the results of the contest to the bargaining strengths of the parties." *H.K. Porter*, 397 U.S. at 107-108. Courts likewise are "referees" that should not alter the parties' obligations under the agreement. Rather, as reflected in this Court's precedent and federal labor policy, a reviewing court should recognize an obligation only when it is evident from the text that such obligation was contemplated and agreed upon *by the parties*. See *Litton*, 501 U.S. at 207; *Am. Nat'l Ins. Co.*, 343 U.S. at 404. Anything more transforms a judge

from a "referee" into a player. Accordingly, the courts of appeals (other than the Sixth Circuit) are rightly reluctant to undercut a collective bargaining party's ability to freely negotiate and agree upon the terms of an agreement.

As this Court recognized in *Pittsburgh Plate Glass*, retirees are frequently part of the negotiating process. 404 U.S. at 175-176. To begin with, retirees are not strangers to the collective bargaining relationship, having started as bargaining unit employees. Nor are they without the protections of federal labor law, which mandates good faith bargaining and provides them a remedy for any contract breaches. *Id.* at 181 n.20 ("The retiree, moreover, would have a federal remedy under § 301 of the Labor Management Relations Act for breach of contract if his benefits were unilaterally changed.").

Indeed, in this case, an affiliate of United Steelworkers, "North America's largest industrial union," which represents more than 1.2 million members throughout multiple countries, represented M&G's employees and retirees in negotiations.[2] This capable and sophisticated group does not need a judicially created advantage.

Further demonstrating the illogic of its approach, even the Sixth Circuit has refused to extend a *Yard-Man*-esque presumption to every retiree welfare benefit plan. Rather, the Sixth Circuit applies *Yard-Man*

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[2] United Steelworkers, http://www.usw.org/union/mission. The Union itself employs nearly 1,800 individuals, has raised nearly $24 million in contributions, and has spent over $6.5 million lobbying federal matters alone. United Steelworkers: Summary, OpenSecrets, https://www.opensecrets.org/orgs/summary.php?id=D000000102&cycle=A.

only to retiree healthcare provisions in collectively bargained agreements. See *Reese* v. *CNH Am. LLC* ("*Reese I*"), 574 F.3d 315, 321 (6th Cir. 2009) ("When the health plan was not collectively bargained, we require a clear statement before we will infer that an employer meant to promise health benefits for life."). Thus, the Sixth Circuit itself would have reached the exact opposite conclusion if M&G had established the same benefits for non-union retirees outside of the collective bargaining context. The Sixth Circuit's treatment of retiree benefits provisions in non-collectively bargained agreements underscores that the *Yard-Man* presumption is an unwarranted anomaly.

3. *Yard-Man*, moreover, significantly distorts the collective bargaining process. As discussed above, if a bargaining party has a right to healthcare benefits, it can *only* be because the collective bargaining parties have agreed to it as a matter of contract. Welfare benefits (unlike pension benefits) do not vest as a matter of law. See 29 U.S.C. § 1051. Accordingly, if a union desires to provide vested welfare benefits for its members, it must bargain for them—and presumably give something else up in exchange. *Yard-Man*, however, turns the tables by presuming that retiree welfare benefits *are* vested, thereby effectively shifting the burden to *employers* to guard *against* vesting.

In this case, for example, the Sixth Circuit effectively required M&G to have obtained an express durational clause stating when retiree welfare benefits expire. Only with such a clause could the company overcome the inference that the parties had the "intent to vest lifetime contribution-free benefits." Pet. App. 20. According to the court below, "[t]o the extent that vesting was presumed, it was not the dis-

trict court that, *sua sponte*, shifted the burden of proof." *Ibid.* Plainly, however, M&G could avoid liability for vested lifetime benefits only one way: an express statement disclaiming the proposition that retiree welfare benefits outlasted the agreement itself. See *Noe*, 520 F.3d at 554 (despite a general durational clause, holding retiree benefits vested based on the absence of any language "specifically stating that retiree health benefits expire upon termination of the agreement"); *Maurer*, 212 F.3d at 917-918 (same). As a matter of practice, M&G would have had to bargain for such an express disclaimer, which is to say, M&G would have had to give up something in return.

Even if that does not amount to shifting the "burden of proof," Pet. App. 20, it most certainly shifts the burden of bargaining. Under a judicially imposed default rule that renders retiree benefits vested and perpetual, employers must make a concession to get an agreement that provides otherwise—which is improper, indeed perverse, given *Curtiss-Wright* and the rule that employers generally have free reign to change or not provide retiree benefits at all. See 514 U.S. at 78. The *Yard-Man* presumption thus unfairly and inappropriately compromises an employer's ability to negotiate a collective bargaining agreement from the outset. In the interest of removing such a judicially created distortion—as the NLRA demands—this Court should rule at a minimum that retiree benefits are *not* presumptively vested.

C. The *Yard-Man* decision fundamentally misinterprets *Pittsburgh Plate Glass* and ignores ERISA's vesting rules.

The Sixth Circuit's *Yard-Man* presumption should be rejected not only for how it elevates silence over the affirmative terms of the parties' agreement, but also because, when the Sixth Circuit created the presumption in the first instance, it misconstrued this Court's precedent and ignored Congress's directive to treat pensions and welfare benefits differently. Rather than endorse this anomalous result, this Court should do what almost every court that has considered the issue has done: reject *Yard-Man*.

1. Interwoven throughout the Sixth Circuit's *Yard-Man* decision are citations to this Court's decision in *Pittsburgh Plate Glass*. See, *e.g.*, *Yard-Man*, 716 F.2d at 1482. But nothing in *Pittsburgh Plate Glass* supports the Sixth Circuit's conclusion that retiree healthcare benefits are "status" benefits that the parties are "unlikely" to have "left to the contingencies of future negotiations." *Ibid.*

In *Pittsburgh Plate Glass*, this Court held that benefits for retired workers are a permissive—not mandatory—subject of collective bargaining, 404 U.S. at 170, 180-82, and that unions have no *duty* to represent retired workers in negotiations with the employer, though they may (and often do) choose to do so, *id.* at 181 n.20. This Court did not hold that retiree benefits are "a form of delayed compensation or reward for past services" that could never be altered. *Yard-Man*, 716 F.2d at 1482. Rather, it recognized that benefits for existing retirees *can* be (and frequently are) the subject of collective bargaining. *Pittsburgh Plate Glass*, 404 U.S. at 170, 180-82. To

consider those benefits presumptively unalterable, therefore, is to proceed from a premise wholly at odds with *Pittsburgh Plate Glass*.

The *Yard-Man* inference, at least in part, stems from the Sixth Circuit's belief that if employees choose to "forego wages now in expectation of retiree benefits, they would want assurance that once they retire they will continue to receive such benefits regardless of the bargain reached in subsequent agreements." *Yard-Man*, 716 F.2d at 1482. Because employees might "want" this result—even though they did not bargain for it—the *Yard-Man* court found "an intent to create interminable rights to retiree insurance benefits in the absence of explicit language [to this effect]." *Ibid.* But this turns *Pittsburgh Plate Glass* on its head. This Court recognized that retiree benefits may be a subject of collective bargaining—so whatever employees may "want" in the way of benefits upon retirement must be bargained for and obtained through affirmative agreement.

Furthermore, because all employees are potential retirees, the union is perfectly fit to bargain over whether benefits will vest. Indeed, as *Pittsburgh Plate Glass* recognized, retirees have a right to enforce contractual promises pursuant to Section 301 of the LMRA. 404 U.S. at 181 n.20. Thus, *Yard-Man's* concern that retirees would be without protection upon leaving the bargaining unit is without merit.

2. Given that Congress intended for pensions and retiree welfare benefits to be treated differently, the Sixth Circuit also misses the mark in finding retiree welfare benefits to be vested based on their mere association with pension benefits. See, *e.g.*, Pet. App. 20; *Noe*, 520 F.3d at 558-559 (citing *McCoy* v. *Meridi-*

an Auto. Sys., Inc., 390 F.3d 417, 419 (6th Cir. 2004); *Golden* v. *Kelsey-Hayes Co.*, 73 F.3d 648, 656 (6th Cir. 1996)). According to the Sixth Circuit, when an agreement "ties" eligibility for pensions and retiree healthcare benefits together (for example, by stating that a pension-eligible employee qualifies for retiree welfare benefits), this indicates "that the parties intended that the company provide lifetime health benefits as well." *Golden*, 73 F.3d at 656.

But like its presumption regarding the parties' likely intent regarding so-called "status" benefits, drawing an inference from the "tying" of welfare benefits and pensions is illogical. Pension benefits vest as a matter of law. Healthcare benefits do not. See 29 U.S.C. § 1051. One important reason for that distinction is that, while pension costs are relatively predictable, healthcare costs are not. See *Int'l Union, UAW* v. *Skinner Engine Co.*, 188 F.3d 130, 138 (3d Cir. 1999) ("Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate," but "[a]utomatic vesting was rejected [for welfare plans] because the costs of such plans are subject to fluctuating and unpredictable variables.") (quoting *Moore* v. *Metro. Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988)).

An agreement may address both benefits together, but that is simply because a retiree may become *eligible* for both benefits at the same point in time. That eligibility connection says nothing about whether the two benefits have the same *duration* or *immutability*. The presumption that merely offering both benefits *ipso facto* vests the otherwise un-vested welfare benefit—without any express language so providing—is untenable and blinks the careful choices Congress made when it enacted ERISA.

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To be clear, *amici* do not contend that employers may not, or even should not, offer retirees a vested right to lifetime healthcare benefits. But employers should not be deemed to have done so where the supposed undertaking is not affirmatively reflected in the parties' agreement—much less where, as here, the agreement has a general durational clause that, on its face, governs retiree benefits provisions (not to mention the cap letters which belie the presumed intent to provide lifetime, uncapped benefits).

II. Finding vested benefits absent affirmative agreement would impose massive retroactive liability on employers and work to the detriment of everyone involved.

An artificial inference of vesting directly or indirectly harms everyone involved—employers, employees, retirees, and even consumers. Among other things, the Sixth Circuit's approach encourages companies to cease providing retiree benefits, threatens to reduce active workers' wages and financial opportunities, and potentially results in increased prices and reduced availability of goods and services. In addition, endorsing *Yard-Man* would negatively affect the employer-employee relationship in numerous ways, including by forcing employers to absorb massive unexpected costs while simultaneously altering the tenor of future labor negotiations. These results are both unwarranted and undesirable.

A. Endorsing *Yard-Man* would lead to massive and unexpected retroactive costs for employers.

To date, very few employers have expressly *disclaimed* the vesting of retiree welfare benefits in their

collective bargaining agreements. That is for good reason: this Court's decision in *Litton*, and the general disapproval of *Yard-Man* by most courts outside the Sixth Circuit. But if this Court embraces *Yard-Man*, it could trigger widespread uncertainty and litigation over expired agreements that could, in many cases, result in far more expensive retiree benefits than employers budgeted.

In the collective bargaining process, employers cost out the expense of proposed wages, benefits, and other terms and conditions of employment over the life of the agreement. A judicial presumption of vesting, imposed post hoc, adds significant uncertainty; not even the parties to the agreement can predict the long-term costs. And in business, with uncertainty comes instability—or even insolvency.[3]

These problems are exacerbated in this context, with the changing regulatory framework, the longer life-expectancy of Americans and swelling retiree ranks, and the high costs of healthcare.

First, *Yard-Man*'s rigid vesting rule makes it costly, difficult, or even impossible for companies to respond when regulatory changes (*e.g.*, the Affordable Care Act) *force* them to alter coverage. See *United Steel, Paper & Forestry, Rubber, Mfg. Energy, Allied Indus. & Serv. Workers Int'l Union, AFL-CIO-CLC* v. *Kelsey-Hayes Co.*, 750 F.3d 546, 555 (6th Cir. 2014) (rejecting company's attempt to replace direct cover-

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[3] Some employers "are being forced into economic restructuring" due to the increased cost of providing health benefits to retirees. United States Social Security Administration, Social Security Advisory Board, *The Unsustainable Cost of Health Care*, September 2009, http://www.ssab.gov/documents/TheUnsustainableCostofHealthCare_508.pdf.

age with equivalent-value vouchers that would have allowed retirees to purchase the coverage best suited to their individual needs).

Second, due to increased life expectancy and the size of the baby boomer generation, the Social Security Administration estimates that the number of Americans over 65 will increase to more than 77 million by 2033 from 46.6 million today.[4] This is an increase of *more than 65 percent* in just 20 years. The fallout from this shift in the active labor force will have effects all through the American economy—and not least in the context of employer-provided healthcare coverage.

Third, total healthcare spending in the United States is expected to reach $5.0 trillion in 2022—up from $2.6 trillion in 2010 and $75 billion in 1970.[5] By 2022, healthcare spending will account for *nearly 20 percent* of gross domestic product.[6] To be sure, retirees will represent a significant part of this cost.

These realities mean that extending *Yard-Man* may force employers to face massive costs for which they did not budget (or agree to). What is more, not only might retroactive vesting of retiree healthcare benefits threaten an employer's bottom-line *today*, the cost of healthcare and the increasing imbalance

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[4] See United States Social Security Administration, *Fact Sheet: Social Security*, http://www.ssa.gov/OACT/FACTS.

[5] See Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2012-2022*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf.

[6] *Id.*

between retirees and active workers may strain an employer's ability to remain solvent and in compliance with its *Yard-Man*-imposed obligations *tomorrow*. See, *e.g.*, *Wood* v. *Detroit Diesel Corp.*, 607 F.3d 427, 436 (6th Cir. 2010) (to save the company from insolvency, the parties needed "to shift the risk of above-cap costs off the company by capping retirees' vested health care benefits").

B. Nearly every party to a collective bargaining agreement suffers from *Yard-Man*'s presumption of vesting.

Imposing significant and unexpected costs on employers for agreements that have already been negotiated will also infect future negotiations over new agreements. Likely, this will be to the detriment of everyone involved.

Affirming the Sixth Circuit's interpretive approach would have far-reaching negative effects on employers. Some may seek concessions in future agreements to account for previously unforeseen financial liabilities. Others may be forced to implement more dramatic workplace changes, such as plant closings or workforce reductions, to offset the newly-incurred legacy costs. Still others may be forced to close their doors altogether.

Employees would suffer, too. Even if retiree benefits are deemed fixed and vested under *Yard-Man*, the benefits, wages, and very jobs of current employees remain negotiable from one agreement to the next. As the Social Security Advisory Board has suggested: "In the long run, most of the impact of rising health care costs on employers can be shifted to their workers by reducing wage growth, hiring fewer workers, or hiring more part-time workers who are typi-

cally not eligible for health insurance coverage."[7] And not only *can* such costs be shifted in these ways, they almost have to be, given that wages and salaries accounted for $6.9 trillion of the $8.6 trillion employers spent on total compensation in 2012.[8] As an employer's largest non-fixed cost (nearly 80% of *total* compensation), active employees are necessarily first in line to shoulder the impact of *Yard-Man*—in the form of both current wages and benefits, and the benefits offered when they themselves retire.

Finally, even retirees are, as a group, better off without the unfairness or uncertainty of a *Yard-Man* type inference. As Judge Sutton has explained, "healthcare benefits—what is provided and what it costs—have not been remotely static in modern memory." *Reese* v. *CNH Am. LLC* ("*Reese II*"), 694

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[7] United States Social Security Administration, Social Security Advisory Board, *The Unsustainable Cost of Health Care*, September 2009, http://www.ssab.gov/documents/TheUnsustainableCostofHealthCare_508.pdf.

[8] See United States Bureau of Economic Analysis, "Table 7.18. Relation of Wages and Salaries in the National Income and Product Accounts to Wages and Salaries as Published by the Bureau of Labor Statistics" (2012 data last revised Aug. 7, 2013), http://www.bea.gov/National/nipaweb/nipawebPreview/TableView.asp?SelectedTable=295&FirstYear=2011&LastYear=2012&Freq=Year&3Place=Y; United States Bureau of Economic Analysis, "Table 7.8. Supplements to Wages and Salaries by Type" (2012 data last revised Aug. 7, 2013), http://www.bea.gov/National/nipaweb/nipawebPreview/TableView.asp?SelectedTable=285&FirstYear=2011&LastYear=2012&Freq=Year&3Place=Y. As Table 7.8 reflects, employers spent $1.7 trillion on employee benefits in 2012, or 19.6% of total compensation.

F.3d 681, 683 (6th Cir. 2012). Accordingly, many retirees "do not want lifetime eligibility for the medical-insurance plan in place on the day of retirement, even if that means they would pay no premiums for it." *Id.* at 683-684. Rather, they "want eligibility for up-to-date medical-insurance plans, all with access to up-to-date medical procedures and drugs"—that is, "something more than a fixed, unalterable bundle of services; they want coverage to account for new and better, yet likely more expensive, procedures and medications than the ones in existence at retirement." *Id.* at 684.

On this basis, the Sixth Circuit has recognized that employers may be permitted to make "reasonable" alterations to coverage, even where retiree benefits are deemed vested under *Yard-Man*. *Reese I*, 574 F.3d at 327. But this is an uncertain and incomplete solution.

Take, for example, the Sixth Circuit's recent decision in *Kelsey-Hayes*. In that case, the employer attempted to shift its retirees' healthcare benefits from traditional group insurance coverage to a system of "Health Reimbursement Accounts." *Kelsey-Hayes*, 750 F.3d at 550. These Accounts "were designed to function, essentially, as a health care voucher system," so the retirees could "use these funds to purchase their own insurance from among a variety of providers." *Ibid.* For 2011, the company had allocated vouchers well in excess of the amount the average employee was expected to need. See *id.* at 550, 557. Nonetheless, the retirees sued the employer *and they won*. The Sixth Circuit, relying heavily on *Yard-Man* and its progeny, held that the collective bargaining agreement's "language alone, *when construed in light of the* Yard-Man *inference*, created a vested lifetime

right to health care benefits." *Id.* at 554-555 (emphasis added). And "whether the [Accounts] are 'better' or 'worse' than the prior group coverages is immaterial as a legal matter * * * the [Accounts] were simply not what was collectively bargained [for]." *Id.* at 557. This kind of rigidity and stagnation is not good for anyone.

In short, *Yard-Man* produces no winners. Employers are forced to operate on a leaner budget, employees are forced to shoulder part of this cost, and retirees may be left with an outdated benefit plan that fails to keep pace with life-saving and life-enhancing medical innovations. These problems, however, can be readily avoided should this Court disavow the *Yard-Man* presumption and require courts to reason not from an ill-founded presumption but rather from the collective bargaining agreement's express terms. Rejecting *Yard-Man* would put negotiating parties on equal footing, facilitate consistent and predictable interpretation of collective bargaining agreements, and ultimately best serve all stakeholders.

CONCLUSION

For the foregoing reasons, this Court should reverse the Sixth Circuit's judgment.

Respectfully submitted.

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AMICUS CURIAE BRIEF

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RECORD AND BRIEFS

IN THE

Supreme Court of the United States

M&G POLYMERS USA, LLC; M&G POLYMERS USA, LLC COMPREHENSIVE MEDICAL BENEFITS PROGRAM FOR EMPLOYEES AND THEIR DEPENDENTS; THE M&G CATASTROPHIC MEDICAL PLAN; THE M&G MEDICAL NECESSITY BENEFITS PROGRAM OF HOSPITAL, SURGICAL, MEDICAL, AND PRESCRIPTION DRUG BENEFITS FOR EMPLOYEES AND THEIR DEPENDENTS; AND THE M&G MAJOR MEDICAL BENEFITS PLAN,

Petitioners,

v.

HOBERT FREEL TACKETT; WOODROW K. PYLES; UNITED STEEL, PAPER AND FORESTRY, RUBBER MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION; AND HARLAN B. CONLEY,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE COUNCIL ON LABOR LAW EQUALITY AND THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS *AMICI CURIAE* IN SUPPORT OF PETITIONER M&G POLYMERS USA, LLC

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QUESTION PRESENTED

Whether, when construing collective bargaining agreements in Labor Management Relations Act cases, courts should presume that silence concerning the duration of retiree health-care benefits means the parties intended those benefits to vest (and therefore continue indefinitely), as the Sixth Circuit holds; or should require a clear statement that healthcare benefits are intended to survive the termination of the collective bargaining agreement, as the Third Circuit holds; or should require at least some language in the agreement that can reasonably support an interpretation that health-care benefits should continue indefinitely, as the Second and Seventh Circuits hold.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. THE TEXT, STRUCTURE, AND POLICY UNDERPINNING ERISA COMPEL THE CONCLUSION THAT LIFETIME VESTING OF WELFARE BENEFITS MUST BE PREDICATED ON CLEAR AND UNMISTAKABLE LANGUAGE	4
II. LAW AND POLICY UNDER THE LMRA COMPEL THE CONCLUSION THAT RETIREE BENEFIT PLANS PROVIDED PURSUANT TO A COLLECTIVE BARGAINING AGREEMENT DO NOT VEST IN THE ABSENCE OF CLEAR AND UNMISTAKABLE LANGUAGE TO THE CONTRARY	16
CONCLUSION	24

TABLE OF AUTHORITIES

CASES Page(s)

14 Penn Plaza LLC v. Pyett,
556 U.S. 247 (2009) 13, 16

Allied Chemical and Alkali Workers, Local Union No. 1 v. Pittsburgh Plate Glass Co.,
404 U.S. 157 (1971) 10-11, 21

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475 U.S. 643 (1986) 22, 23

Barnhart v. Sigmon Coal Co.,
534 U.S. 438 (2002) 6

Bethlehem Steel Co. v. NLRB,
320 F.2d 615 (3d Cir. 1963) 18

Curtiss-Wright Corp. v. Schoonejongen,
514 U.S. 73 (1995) ..... *passim*

Fifth Third Bancorp v. Dudenhoeffer,
134 S. Ct. 2459 (2014) 15

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.,
520 U.S. 510 (1997) 6, 9, 23

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501 U.S. 190 (1991) 18, 19

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460 U.S. 693 (1983) 22, 23

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Russello v. United States, 464 U.S. 16 (1983) 6-7

Sengpiel v. B.F. Goodrich Co., 156 F.3d 660 (6th Cir. 1998) 9, 15

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 5

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TABLE OF AUTHORITIES—Continued

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365 U.S. 95 (1962) 17

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353 U.S. 448 (1957) 17

Transportation-Communications Employees Union v. Union Pacific, R.R.,
385 U.S. 157 (1986) 17

UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) 23

UAW v. Yard-Man, Inc.,
716 F.2d 1476 (6th Cir. 1983) 10, 16

UMWA Health and Retirement Funds v. Robinson,
455 U.S. 562 (1983) 12, 13

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145 F.3d 850 (7th Cir. 1998) 16

United Steel, Paper and Forestry, Rubber, Mfg. Energy, Allied Industrial and Service Workers Int'l. Union v. Kelsey-Hayes Co.,
750 F.3d 546 (6th Cir. 2014) 8

STATUTES

Coal Industry Retiree Health Benefits Act of 1992, 26 U.S.C. § 9711(a) 19

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, tit. X, 100 Stat. 327 (1985) 5

TABLE OF AUTHORITIES—Continued

Page(s)

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29 U.S.C. § 1053 5

29 U.S.C. § 1053(a) 19

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29 U.S.C. § 1132(a)-(m) 6

Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) 5

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29 U.S.C. § 158(a)(5) 18

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TABLE OF AUTHORITIES—Continued

Page(s)

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INTEREST OF THE *AMICI CURIAE*[1]

The Council on Labor Law Equality (COLLE) is a trade association founded over thirty years ago for the purpose of monitoring and commenting on developments in the interpretation of the National Labor Relations Act (NLRA) and related statutes. COLLE represents employers in virtually every business sector. Through the filing of *amicus* briefs and other forms of participation, COLLE provides a specialized and continuing business community effort to maintain a balanced approach in the formulation of national labor policy on issues that affect a broad cross-section of American industry. COLLE is the nation's only brief-writing association devoted exclusively to issues arising under the NLRA and related statutes, and in recent decades has filed *amicus* briefs in nearly every significant labor case before the National Labor Relations Board, the federal courts of appeals, and the U.S. Supreme Court.

COLLE members have a vital interest in ensuring that welfare benefit plans negotiated in collective bargaining agreements are interpreted in a manner consistent with welfare plans employers implement voluntarily, without the subsequent interjection of interpretative "presumptions" or "inferences" by the federal courts. COLLE is uniquely situated to inform the Court concerning the issues raised under the

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[1] Pursuant to Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici*, their members, or their counsel have made any monetary contributions intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), *amici* state that letters reflecting the parties' blanket consent to the filing of *amicus* briefs have been filed with the Clerk's office.

Employee Retirement Income Security Act (ERISA) and the Labor Management Relations Act (LMRA) in this case, and the impact this Court's interpretation will have in applying those statutes to the entire business community.

The Society for Human Resource Management (SHRM) is the world's largest HR membership organization devoted to human resource management. Representing more than 275,000 members in over 160 countries, the Society is the leading provider of resources to serve the needs of HR professionals and advance the professional practice of human resource management. The purposes of SHRM, as set forth in its by-laws, are to promote the use of sound and ethical human resource management practices in the profession, and to: (a) be a recognized world leader in human resource management; (b) provide high-quality, dynamic, and responsive programs and services; (c) be the voice of the profession on human resource management issues; (d) facilitate the development and guide the direction of the human resource profession; and (e) establish, monitor, and update standards for the profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China, India and United Arab Emirates.

SHRM frequently represents its membership though the filing of *amicus curiae* briefs with courts throughout the United States in matters of common concern to human resource professionals.

SUMMARY OF ARGUMENT

Unlike pension plans, welfare plans are not subject to the vesting provisions of ERISA. The congressional policy behind this exclusion for welfare plans, and the necessity of clear language to signify a contrary intent, applies with equal force to health-care plans established unilaterally under ERISA and health-care plans established pursuant to collective bargaining under the LRMA. Indeed, in important respects the policy for requiring clear and unmistakable language to vest welfare benefits in collectively bargained plans is even more compelling.

The LMRA further underscores that an employer's commitment to inalterably vest retiree health benefits must not be presumed, but require instead clear and unmistakable language of assent. Federal common law developed under the LMRA provides that any waiver of substantive rights must be based on the existence of clear and unmistakable contractual language, and that interpretive distinctions drawn on the basis of union membership are suspect. Further, normal rules of contract interpretation support the notion that a waiver of rights, and/or the establishment of an exception to the general rule that an employer's contractual obligations terminate when the labor agreement expires, requires language clearly expressing such intention.

The imperative to establish a uniform labor policy requires a consistent and easy to understand test for determining when, in the case of a health plan created in collective bargaining, retirees become vested in a right to receive health-care benefits that cannot be either terminated or altered after the contract itself has expired. The only test consonant with ERISA, federal common law under the NLRA, and general

principles of contract law, is one which requires clear and unmistakable language evincing the plan sponsor's intention to vest retired participants in a right to receive such significant and costly employer-provided benefits in perpetuity. This Court has endorsed the clear and unmistakable standard in other contexts involving important statutory rights in the collective bargaining context, and that test is appropriately applied to adjudication of the important rights at issue here.

ARGUMENT

I. THE TEXT, STRUCTURE, AND POLICY UNDERPINNING ERISA COMPEL THE CONCLUSION THAT LIFETIME VESTING OF WELFARE BENEFITS MUST BE PREDICATED ON CLEAR AND UNMISTAKABLE LANGUAGE

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, *et seq.*, is a "comprehensive and reticulated statute" governing employee pension and welfare benefit plans that was enacted by Congress after almost a decade of study. *Nachman Corp. v. PBGC*, 446 U.S. 359, 361 (1980). Notwithstanding the broad protections ERISA provides for benefit plan participants (especially pension plan participants), nothing in ERISA creates substantive rights to employer-provided health benefits. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans").

Accordingly, both the text and structure of ERISA differ markedly between employee *pension* plans and employee *welfare* plans, including health-care benefit

plans. ERISA imposes comprehensive vesting and funding requirements on all employee pension plans, *see* 29 U.S.C. §§ 1053, 1082, 1083, 1084, but exempts welfare plans (including health-care plans) from these same exacting requirements. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90-91 (1983). Significantly, while both chambers of the 93rd Congress chose to protect vested pension benefits as "accrued benefits," that term and that protection was never intended to apply to group health coverage. *See* H.R. Rep. No. 93-807 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4726; S. Rep. No. 93-383 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4889, 4935. Accordingly, because ERISA specifically exempts welfare plans from any vesting requirement, sponsors of health benefit plans generally have the right to modify or terminate them at any time. *Curtiss-Wright*, 514 U.S. at 78.

The 93rd Congress's differentiation between welfare plans and pension plans has endured for decades notwithstanding subsequent amendments to ERISA and legislation specifically addressing welfare benefit plans. *See, e.g.*, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, tit. X, 100 Stat. 327 (1985); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996). If this national policy, set out in one of the most significant and impactful legislative undertakings in the last forty years, is to be changed, that adjustment is most appropriately accomplished by the Congress, not through the device of a judicially created interpretative presumption. *See, e.g., Senate Sets Sights on Retiree Benefit Vesting; ERISA Amendments Create New Presumption*, Pens. & Ben. Daily (BNA) (June 17, 2014) (discussing Bankruptcy Fairness and Employee Benefits Protection Act (S. 2418) designed to add

subsection (n) to ERISA's existing civil enforcement scheme, 29 U.S.C. § 1132(a)-(m), to codify a vesting presumption for retiree health-care benefits).

Congress's distinct and disparate treatment of welfare plans does not depend on whether the plans are the subject of collective bargaining. For example, while Congress amended ERISA to further safeguard the rights of beneficiaries upon termination of collectively bargained, multi-employer pension plans, *see* Multiemployer Pension Plan Amendments Act of 1980, Pub. L. No. 96-364, 94 Stat. 1208 (1980), it has repeatedly declined to alter welfare plans' exclusion from ERISA's vesting, participation and cutback prohibitions. *See, e.g., Senate Committee on Aging Criticizes Lack of Protection for Retiree Health and Life Insurance Benefits*, Daily Report for Executives (BNA) A-2 (Aug. 4, 1986); H.R. 5475, 98th Cong. (1985) (designed to amend Title I of ERISA to presume a lifetime health benefit entitlement); *Emergency Retiree Health Benefits Protection Act of 2001*, H.R. 1322, 107th Cong. (2001) (designed to prohibit termination of retiree health benefits even if the employer's health plan reserves a general power to terminate or modify the plan).

The enduring substantive distinction drawn by Congress between pension plans and welfare plans was presumptively purposeful and intentional. *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997); *accord Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452-54 (2002) ("where Congress wanted to provide for successor liability [for LMRA-based retiree health benefits] in the Coal Act it did so explicitly") (citing *Russello v. United States*, 464 U.S. 16, 23 (1983)

("generally presumed Congress acts intentionally and purposefully" in its textual exclusion)).

Congress recognized the need for ongoing flexibility in designing and maintaining *welfare* plans when it declined to impose vesting requirements similar to those imposed on pension plans:

> Automatic vesting [of welfare benefits] was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. . . . [M]edical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs.

Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988). While future liability for a pension annuity can be ascertained and projected with considerable accuracy, welfare benefits—especially health benefits—are affected by unpredictable variables and changing circumstances such that the future cost of providing welfare benefits is not readily ascertainable by employers. *Id.*

Indeed, as recent history illustrates, the cost of providing a health-care plan is subject to significant and unpredictable escalation; and the entire health-care market and delivery system may be subject to a host of consequential changes that can directly impact the architecture of any health-care plan, including changes imposed by the Legislature.[2] *See, e.g.*, Medicare

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[2] In a recent report to Congress, the Office of the Actuary for the Centers for Medicare and Medicaid Services estimated that 65% of small employers offering health insurance to their employees will experience an increase in premium costs when the

Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2609 (2012) ("In enacting the [ACA], Congress comprehensively reformed the national market for health-care products and services.") (Ginsburg, J., dissenting); *United Steel, Paper and Forestry, Rubber, Mfg. Energy, Allied Industrial and Service Workers Int'l. Union v. Kelsey-Hayes Co.*, 750 F.3d 546, 562 (6th Cir. 2014) ("the one constant in healthcare is change") (Sutton, J., concurring in part and dissenting in part).

Given both the unpredictability of future costs and the changing circumstances within which such

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guaranteed issue, guaranteed renewal, and fair health insurance premiums provisions of the Affordable Care Act take effect. *See* Centers for Medicare & Medicaid Services, Office of the Actuary, *Report to Congress on the impact on premiums for individuals and families with employer-sponsored health insurance from the guaranteed issue, guaranteed renewal, and fair health insurance premiums provisions of the Affordable Care Act*, 5 (Feb. 21, 2014), *available at* http://www.cms.gov/Research-Statistics-Data-and-systems/Research/ActuarialStudies/ReportCongress.html. *See also* Bureau of Labor Statistics, *Employer Costs for Employee Compensation news release text* (June 11, 2014), *available at* http://www.bls.gov/news.release/ecec.nr0.htm (employer health-care benefits accounted for 7.9% of total compensation in 2014 versus 6.6% in 2004. These figures significantly increase for unionized workers where, in 2014, employer health benefits accounted for 12.6% of compensation costs.); Altarum Institute, *Health Sector Economic Indicators, Insights from Monthly Price Indices Through April 2014* (June 12, 2014), *available at* http://altarum.org/sites/default/files/uploaded-related-files/CSHS-Price-Brief_June%202014.pdf (since the December 2007 recession health-care prices have increased by 14.3% while prices in the economy as a whole have only risen 9.8%).

benefits are provided, Congress carefully exempted welfare plans from any vesting requirement to ensure that employers retained the "flexibility" to deal with all of the contingencies that attend employee welfare plans. *Inter-Modal*, 520 U.S. at 515. Making such plans fixed and immutable would make the ability to deal with these contingencies impossible, and thus discourage the creation of such welfare plans in the first place, thereby undermining Congress's express design. *Id.*

Absent clear language to the contrary, an employer providing a welfare plan is free to modify benefits or eliminate the plan at any time. *Curtiss-Wright*, 514 U.S. at 78. Indeed, in the instance of a non-collectively bargained retiree welfare plan it is well established (even within the Sixth Circuit) that, while an employer may choose to vest the benefits it provides, the prohibition against future modification or termination which vesting entails *cannot be inferred or presumed from silence*, but requires that the prohibition be articulated in "clear and express language." *Sengpiel v. B.F. Goodrich Co.*, 156 F.3d 660, 667 (6th Cir. 1998).

What is true for ERISA plans which are unilaterally established and administered should apply with equal force to LRMA collectively bargained welfare plans. In terms of vesting, ERISA provides no basis for differentiating between a benefit plan an employer implements unilaterally, and the same benefit plan an employer implements pursuant to a bilaterally negotiated collective bargaining agreement. ERISA draws no textual or policy distinction between the two, and both are subject to the same future cost and architectural uncertainties that underlie the welfare plan exemption from any vesting requirement.

Despite the fact that ERISA makes no relevant distinction between the two types of welfare plans, and logic dictates that both be treated the same, the Sixth Circuit has adopted a line of judicial thinking that effectively stands ERISA's anti-vesting presumption on its head in the instance of collectively bargained plans. The most notable example of this judicially manufactured carve-out originated in the Sixth Circuit's *Yard-Man* decision. *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983).

Yard-Man does not purport to base its differing treatment of collectively bargained retiree health plans on the text of ERISA, since no textual authority supports the notion. Rather, the judicially created exception arises from the court's characterization of the process whereby the welfare benefit is created in the collective bargaining context. Even assuming *arguendo* that such "process" considerations could suffice to overcome the consequence of ERISA's plain language, and the contrary commands of federal common law under the LMRA, *see* Part II *infra*, these cited process considerations are simply unpersuasive.

The *Yard-Man* decision rests its presumption in favor of vesting collectively bargained retiree welfare benefits on two policy-related arguments. First, the court posits that since such benefits are tied to the recipients' "status" as retirees, the benefit should continue as long as the recipient maintains the status of "retiree." *Yard-Man*, 716 F.2d at 1482. Second, since benefits for already retired employees are only "permissive" subjects of bargaining, such a presumption is necessary to protect retirees from their former union's presumed indifference to the maintenance of such benefits in successive collective bargaining agreements. *Id.*; *see Allied Chemical and Alkali*

Workers, Local Union No. 1 v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971). Upon close inspection, neither argument is grounded in logic.

The fact that retiree benefits are applicable to retirees is self-evident and not alone sufficient to create a presumption of vesting. This is apparent when one considers that outside of the realm of collective bargaining, unilaterally provided retiree welfare benefit plans likewise apply to "retirees." Yet, in the absence of clear and express vesting language, retiree welfare plans that are not the result of collective bargaining can be modified or terminated at any time without regard to the fact that participants in those plans also maintain their "retiree status." *Curtiss-Wright*, 514 U.S. at 78 ("[T]hat Curtiss-Wright amended its plan to deprive [retired plan participants] of health benefits is not a cognizable complaint under ERISA; the only cognizable claim is that the company did not do so in a permissible manner."). The mere fact that the retiree benefit offered under a plan was the subject of collective bargaining cannot supply an independent basis for elevating the "status" of the recipients into a determinative factor for establishing vesting. Since retiree status is present whether the plan is administered unilaterally or is subject to collective bargaining, there is no logical reason for according "status" dispositive effect in the context of a collectively bargained plan but no effect whatsoever in the context of a non-collectively bargained plan. Assigning vesting consequence to the "status" of retired participants who receive health benefits from their former employer is circular, and sheds no light on the real question: does the language in the plan (or labor agreement or employment contract) express a clear intent by the plan sponsor to convey to a participant a legally enforceable right to receive

benefits under the plan for a specified time (e.g., for life) and at a specified level which the employer is not at liberty to change?

Similarly, the Sixth Circuit's second rationale—that a vesting presumption is justified because bargaining about benefits for retired employees is permissive—does not withstand scrutiny. First, such a presumption actually does a disservice to unions and the employees they represent, as well as the employers who bear the financial consequences. It may well be true that every employee desires an enforceable right to receive employer-provided health-care benefits for life. However, when a court relies on a judicially created presumption to vest former employees (or their dependents) in a right to receive such benefits, even in the absence of language clearly reflecting a mutual agreement between the employer and the employees' union to this end, the court has preempted the ability of the parties to bargain about the matter in the future. *See UMWA Health and Retirement Funds v. Robinson*, 455 U.S. 562, 575 n.14 (1983) (noting that under established contract principles "vested retirement rights may not be altered without the pensioner's consent.").

The cost of providing retiree health benefits is significant and consequential. Over time this "legacy" burden can adversely impact a unionized employer's competitiveness, and impinge on a union's ability to negotiate wages and other benefits for its active members (including *their* health benefits). Assigning a presumption as the Sixth Circuit has done here can have dire—if unintended—consequences. It is not unusual for employers that have accrued sizeable retiree health-care obligations that cannot be modified to be forced into bankruptcy or even liquidation.

Where employers and unions have knowingly entered into agreements that vest retirees in such a costly benefit they must accept the consequences, of course. But national labor policy is not served by a judicial presumption that excludes from the collective bargaining process the ability of union and management representatives to permissively address through good faith—even contentious—negotiations the economic realities they may face with respect to welfare benefits provided to former employees. *See Robinson*, 455 U.S. at 566-67 (recounting intense bargaining over conferring lifetime health benefits to certain classes of surviving spouses of union retirees). In *Robinson*, the Court rejected an invitation to review the parties' health benefit vesting compromise for "reasonableness" recognizing that "when neither the collective-bargaining process nor its end product violates any command of Congress, a federal court has no authority to modify the substantive terms of a collective-bargaining contract." *Id.* at 576.

Second, the Sixth Circuit's concern about permissive bargaining is premised on the assumption that a union has no interest in continuing to secure benefits for retirees in successive collective bargaining agreements. This assumption is unfounded because today's employees (for whom a union clearly has an interest) are tomorrow's retirees. Moreover, assuming *arguendo* that the concern may in some cases have merit, it cannot supply a basis for creating a judicial presumption in favor of vesting in the absence of any statutory support. *See 14 Penn Plaza LLC v. Pyett*, 556 U.S. 247, 270 (2009) (enforcing "clear and unmistakable" bargaining agreement language committing unionized employees' federal age discrimination claims to labor arbitration over employees' claims of a union conflict of interest, concluding that the

courts cannot rely on a judicial policy concern as a source of authority for introducing a qualification not found in the statutory text).

Third, presuming that an employer is disinclined to provide retiree benefits in successive bargaining agreements simply because the topic is not a mandatory subject of negotiations, is at odds with the ample evidence that (as in the instant case) employers routinely permit retirees to participate in the employer's health plan over multiple collective-bargaining agreements. Moreover, it also fails to recognize the many ways employers are advantaged by providing benefits to retirees, such as competitiveness in recruitment of new employees, the retention of current employees, and the maintenance of harmonious labor relations.

Finally, retiree benefit plans that are not collectively bargained are the product of unilateral implementation where there is neither a negotiation with employee representatives nor an assumed level of contractual or language sophistication on the part of employee or retiree beneficiaries. The Sixth Circuit never explains why it is logical to afford a vesting presumption to retirees who have an advocate (i.e., their union representatives), but not afford a presumption to non-union retirees who have no advocate.

In actuality, the introduction of a presumption in favor of vesting in the context of negotiated plans, but not unilaterally implemented plans, is *illogical*. As the Seventh Circuit aptly noted, this difference would actually support the argument for a vesting presumption in the context of *unilaterally created* welfare plans. *Rossetto v. Pabst Brewing Co.*, 217 F.3d 539, 543-544 (7th Cir. 2000). Yet, even the Sixth Circuit concedes that in the context of a unilaterally

established plan, no presumption of vesting arises out of silence, but requires "clear and express language." *See Sengpiel*, 156 F.3d at 667; *see also Sprague v. General Motors Corp.*, 133 F.3d 388, 400 (6th Cir. 1998). *A fortiori*, silence in a collective bargaining agreement concerning the duration of benefits to be provided under the agreement should never give rise to a presumption in favor of vesting. Vesting should only be predicated on the existence of clear and unmistakable language demonstrating the employer's intention to convey to a participant the right to receive, indefinitely, a benefit that the employer cannot modify or terminate after the contract has terminated.

This Court has recently made clear that constructive "presumptions" under ERISA must be drawn from the text of the statute. Thus, in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), the Court rejected a presumption of prudence in certain stock sales regulated under ERISA that was far more broadly accepted by lower federal courts than the presumption at issue herein. In doing so, this Court noted that that the statutory reference cited as one of the bases for the presumption of prudence at issue, "makes no reference to a special 'presumption' in favor of ESOP beneficiaries." *Id.* at 2467. Thus, like the presumption of prudence in *Fifth Third Bancorp*, a presumption in favor of the vesting of retiree benefits lacks the necessary anchor in statutory text. *See, e.g.*, Bankruptcy Fairness and Employee Benefits Protection Act, S. 2418, 113th Cong. (2014) (proposing to codify a statutory "presumption" in ERISA that retiree health benefits "fully vest[]" as of "the date an employee retires or completes 20 years of service.").

Since ERISA provides no textual or policy support for the Sixth Circuit's *Yard-Man* presumption favoring vesting of retiree welfare benefits, federal labor law governing the collective bargaining process provides the only other plausible source for such a presumption. As we now show, a presumption against vesting welfare benefits is even stronger under the law and policy that govern collective bargaining.

II. LAW AND POLICY UNDER THE LMRA COMPEL THE CONCLUSION THAT RETIREE BENEFIT PLANS PROVIDED PURSUANT TO A COLLECTIVE BARGAINING AGREEMENT DO NOT VEST IN THE ABSENCE OF CLEAR AND UNMISTAKABLE LANGUAGE TO THE CONTRARY

The Labor Management Relations Act, 29 U.S.C. §§ 141, *et seq.*, was enacted in part by Congress to "create a national, uniform body of labor law and policy, to protect the stability of the collective-bargaining process, and to maintain peaceful industrial relations." *United States v. Palumbo Bros. Inc.*, 145 F.3d 850, 861 (7th Cir. 1998); 29 U.S.C. § 151, *et seq.* Pursuant to the LMRA, a unionized employer and its employees' authorized agent for collective bargaining negotiate labor contracts that memorialize the parties' agreement with respect to wages, hours, working conditions and other terms and conditions of employment. *See, e.g.*, 29 U.S.C. § 157; *Pyett*, 556 U.S. at 255; *NLRB v. City Disposal Sys., Inc.*, 465 U.S. 822, 829 (1984). In many cases these collective bargaining agreements contain language that provides health and other welfare benefits to former employees, including retirees.

The existence of multiple and conflicting interpretive standards for resolving vesting issues in welfare plans established in collective bargaining is contrary to the aspirational goal of establishing a uniform national labor policy. *Textile Workers v. Lincoln Mills of Ala.*, 353 U.S. 448, 451 (1957); *Teamsters v. Lucas Flour Co.*, 365 U.S. 95 (1962). Rather than engendering a uniform federal policy, the present interpretative standards have resulted in incompatible, policy-based decisions that sow the seeds of uncertainty.[3] A uniform policy requires a bright-line interpretive standard. The only standard that harmonizes the policy commands of both ERISA and the LMRA, and that satisfies the uniformity criteria of the LMRA is one requiring "clear and unmistakable" language.

Section 301 of the LRMA, 29 U.S.C. § 185, provides a federal cause of action for the breach of labor-management agreements, and authorizes federal courts to "fashion a body of federal law for the enforcement of collective bargaining agreements." *Lincoln Mills*, 353 U.S. at 451. Under section 301, normal rules of contract interpretation are applied in conjunction with federal labor policy. *Transportation-Communications Employees Union v. Union Pacific, R.R.*, 385 U.S. 157 (1986). Federal common law treats the terms of a collective bargaining agree-

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[3] *See generally* A. Kramer, *et al., Retiree Health Benefits: Legal Developments in a Changing Global Economy* (Aug. 2008), *available at* http://www.jonesday.com/files/Publication/b862f89d-f5f8-445f-8344-aa037c82b669/Presentation/PublicationAttachment/008b578a-4949-4371-b8e3-f557edc34941/JD~4294925.pdf.; A. Weisman, *Vested Right of Retiree to Promised Medical Insurance Benefits from Private Employer*, 74 A.L.R. 6th 267 (2010) (surveying lower court case law).

ment, including those that provide health or other benefits, as ending with the contract's expiration. *Litton Fin. Printing Div. v. NLRB*, 501 U.S. 190, 207 (1991) ("[C]ontractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement."); *Laborers Health and Welfare Trust Fund for N. Cal. v. Advanced Lightweight Concrete Co.*, 484 U.S. 539 (1988) ("If the labor legislation were simply repealed, *in toto*, petitioner would have no basis whatsoever for claiming that an employer had any duty to continue making contributions to a fund after the expiration of its contractual commitment to do so."); *Office and Professional Employees Ins. Trust Fund v. Laborers Funds Admin. Office of N. Cal. Inc.*, 783 F.2d 919, 922 (9th Cir. 1986) ("An expired [collective bargaining agreement] is no longer a legally enforceable document."); *Bethlehem Steel Co. v. NLRB*, 320 F.2d 615, 619 (3d Cir. 1963) ("Since there was no contract in existence when the company discontinued these practices, its action was in conformity with the law.").[4]

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[4] Under the NLRA's "unilateral change" doctrine, certain provisions of a collective bargaining agreement may temporarily survive its expiration. *NLRB v. Katz*, 369 U.S. 736 (1960). Thus, under section 8(a)(5) of the National Labor Relations Act, 29 U.S.C. § 158(a)(5), terms and conditions, including benefits, may temporarily remain in effect following the expiration of a collective bargaining agreement while the parties either bargain to a new agreement on new terms, or to impasse. This temporary extension of the *status quo* beyond the contract's expiration should not be confused with contractual obligations or vesting. *See Laborers Health and Welfare Trust Fund for N. Cal.*, 484 U.S. at 553 (distinguishing between same in a case involving post-expiration pension contributions); *Litton Fin. Printing Div.*, 501 U.S. at 207. The *Katz* unilateral change doctrine merely preserves certain provisions of an expired collective bargaining agreement until the terminal point of negotiations where all such

Benefits provided under a collective bargaining agreement may, of course, vest where vesting is dictated by external federal law, such as pension benefits under ERISA. *See, e.g.*, 29 U.S.C. § 1053(a) ("employee's right to his normal [pension] benefit is nonforfeitable"). Congress may also vest welfare benefits by separate legislation. *Cf.* Coal Industry Retiree Health Benefits Act of 1992, 26 U.S.C. § 9711(a) (statutory vesting of lifetime health benefits for certain retired union bituminous coal miners). However, Congress enacted no such legislation vesting the retiree health-care benefits at issue here.

A contractual provision may also vest current employees or retirees in a right to receive benefits after expiration of the collective bargaining agreement where the agreement demonstrates with sufficient clarity an intention by the parties to override the general principle that "an expired contract has by its own terms released all its parties from their respective contractual obligations." *Litton Fin. Printing Div.*, 501 U.S. at 206. Thus, while vesting current or former employees in a right to receive benefits post-contract expiration is possible, it is the exception and not the rule. The normal rules of contract interpretation require clear language to establish the existence of an exception. This observation is particularly apt in the present instance.

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provisions are subject to modification or termination. Its application does not entitle any person to receive any benefit under the terms of the expired agreement once the parties have complied with the collective bargaining obligations imposed on them by the NLRA.

General principles of contract interpretation, aided by common sense, dictate the conclusion that silence[5] does not signify a party's intent to forever waive its legal right to modify or terminate at the contract's end a provision that exposes it to a future substantial, unpredictable, and escalating liability. A contracting party's acceptance of an obligation so onerous, unending, and unpredictable cannot and should not simply be presumed. *See* 11 Richard Lord, *Williston on Contracts* § 31.6 (4th ed.) (2014) ("[a]dditional obligations or undertakings may not be imposed on a party under the guise of interpreting or construing a contract"); *see also id. at* § 30.6 (the duty of the court being to declare the meaning of what is written in the instrument, not what was intended to be written). General principles of contract interpretation require an obligation of such a character be predicated on clear and explicit language. ("[T]he law presumes that when the parties to a contract entered into it, they understood not only the meaning of the words and phrases they used in their agreement but also their

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[5] No collective bargaining agreement is ever truly "silent" with respect to retiree health-care vesting, because all collective bargaining agreements contain a general duration clause providing for the expiration of the contract. While the contract provision providing for retiree welfare benefits may not have specific language *within that clause* providing for termination of that particular benefit (as the Sixth Circuit insists be present), that does not entitle a party to a presumption that the benefit clause remains in effect in perpetuity. Quite the opposite is true. The general duration clause breaks any claimed "silence;" and the duration clause must be given dispositive effect *in the absence of clear language* which compels a contrary result. H. Shulman, *Reason, Contract and Law in Labor Relations*, 68 Harv. L. Rev. 999, 1018 (1956) ("the interpretation which is most compatible with the agreement as a whole is to be preferred over one which creates anomaly.")

significance"); *see also* 20 Richard Lord, *Williston on Contracts* §§ 55.20, 55.23 (4th ed.) (2014).

These general principles of contract interpretation are mirrored in the federal law as developed under the LMRA, and compel the same conclusion. Indeed, these principles are especially applicable in the context of collective bargaining, which is conducted by sophisticated parties with a long and continuous history of negotiating their labor agreements, typically involving the same negotiators sometimes for decades. They are attuned to the importance of language memorializing their respective undertakings, due in part to the fact their ongoing relationship is more adversarial than the typical commercial contract.[6] When the judiciary invokes a presumption to vest a benefit the union did not clearly obtain in collective bargaining,

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[6] Union negotiators are well aware that bargaining about current employees' future benefits is mandatory; *see Midwest Power Systems, Inc.*, 323 NLRB 404, 406 (1997) ("The Supreme Court has clearly stated that the future retirement benefits of current active employees are a mandatory subject of collective bargaining under the Act"), *enf. denied on other grds.*, 159 F.3d 636 (D.C. Cir. 1998); whereas bargaining on behalf of already retired individuals is permissive. *Pittsburgh Plate Glass*, 404 U.S. at 181-82. Bargaining about retiree health benefits is the product of bilateral negotiation between two experienced parties, and union negotiators are well-versed in drafting contractual language that would unmistakably vest a benefit when there is mutual agreement to do so. Thus, knowing that once an individual is retired the union loses the leverage associated with a mandatory topic of bargaining, if union representatives secured in negotiations retiree health benefits for current employees that survive contract expiration they would not leave that very important benefit to be inferred from contractual silence. The burden is on the union to lock in with clear and unmistakable language any agreement it has obtained from an employer to vest current employees in this very important benefit.

the court has put its thumb on the balance of the parties' rights and obligations as established under ERISA and the LMRA.

As discussed in Part I, *supra*, employers have the statutory right under ERISA to modify or terminate a welfare benefit plan, including a health-care plan. Federal common law applicable to the interpretation of collective bargaining agreements has long held that the relinquishment of such a statutory right requires "clear and unmistakable" language signifying a waiver of that right. *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693 (1983). As the Court observed in *Metropolitan:*

> we will not infer from a general contractual provision that the parties intended to waive a statutorily protected right unless the undertaking is 'explicitly stated.' More succinctly, the waiver must be clear and unmistakable.

Id. at 708 & n.12.

While *Metropolitan* involved the waiver by a union of a represented employee's rights, the Court's logic applies with equal force in analyzing the purported waiver of the *employer's* statutory rights in the instant case.[7] Thus, under ERISA, the sponsor of a welfare

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[7] *Metropolitan* has been applied in other factual settings. For example, in *AT&T Tech., Inc. v. Communication Workers of America*, 475 U.S. 643 (1986), the Court citing *Metropolitan*, required "clear and unmistakable" language to find a waiver of the parties' right to have a federal court determine the scope of the arbitration clause in their collective bargaining agreement. *Id.* at 649. The Court further noted that the willingness of parties to enter into labor agreements that provide for arbitration of specified disputes would be "drastically reduced" if an arbitrator had the power to determine his own jurisdiction. *Id.* at 651.

benefit plan has a statutory right to modify or terminate that plan "at any time." *Inter-Modal*, 520 U.S. at 515 (quoting *Curtiss-Wright*, 514 U.S. at 78). Vesting a participant in a right to benefits under a welfare plan is an affirmative commitment by the employer pursuant to which the employer waives its right to amend and maintain control over the plan. Under the logic of *Metropolitan*, and well-settled principles of contract law, judicial enforcement of a waiver of such substantial and significant rights should require clear and unmistakable language expressing the employer's intention to do so. *See* 11 Richard Lord, *Williston on Contracts* § 39.28, (4th ed.) (2014) ("An intent to waive will not be inferred from doubtful or equivocal acts or language; rather, in the absence of an express declaration manifesting the intent not to claim the right allegedly waived, there must be a clear, unequivocal, and decisive act of the party who is claimed to have waived its rights"). The thrust of *Metropolitan*, and of contract law in general, is wholly in accord with the view espoused by the Third Circuit that an employer's supposed commitment to the provision of vested health benefits is not to be "lightly inferred," *UAW v. Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999), and is entirely consistent with this Court's longstanding "clear and unmistakable" test for waiving statutory rights in LMRA cases.

Finally, the presumption in favor of vesting for collectively bargained plans, but not for non-bargained plans, is contrary to other fundamental policy principles underpinning federal labor law because this

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The necessity of clear language evincing a waiver, and the consequence of imposing a presumption in the face of silence noted in *AT&T* are equally apt here.

artificial and unfounded distinction affords significantly more favorable interpretive treatment to plan participants who claim benefits from collectively bargained ERISA plans. Thus, the Sixth Circuit accords employees who are, or were, represented by a labor organization a significant favorable presumption of vesting where the governing documents are silent with respect to the issue of duration or vesting. By contrast, their counterparts who were not represented by a labor organization receive no similar presumption in the face of silence on the issue of vesting. At its core, this constitutes impermissible discrimination between two sets of retirees that is ostensibly based on no factor other than their present or former union affiliation. The LMRA makes it unlawful for an employer or a union to discriminate on such a basis and, as a matter of federal labor policy, federal courts should not rest an interpretive presumption on that same discriminatory basis. 29 U.S.C. §§ 157, 158(a)(1), (b)(1).

CONCLUSION

The presumption that a party has waived important rights by virtue of silence finds no support in ERISA, or in federal common law as developed under the LMRA, or under general principles of contract interpretation. National labor policy requires a uniform test for establishing when, in a collectively bargained labor contract, the parties intended to vest retirees in a right to receive health-care benefits which cannot be altered or terminated after the contract has expired, even though the parties may subsequently agree that changes are desirable. The only test consonant with both federal common law under the LMRA and the principles of general contract law is one which requires clear and unmistakable language

evincing an employer's intention to vest plan participants in such an important and costly benefit.

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AMICUS CURIAE BRIEF

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M&G POLYMERS USA, LLC, ET AL.,

Petitioners,

v.

HOBERT FREEL TACKETT, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE ERISA INDUSTRY COMMITTEE AND THE AMERICAN BENEFITS COUNCIL AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 6

I. This Court Should Set Forth Predictable Rules Regarding The Vesting Of Retiree Healthcare Benefits. 6

II. An Intent To Vest Retiree Healthcare Benefits Must Be Stated In Clear And Unambiguous Terms. 10

III. The Court Should Expressly Reject The Flawed Rules Of Contract Interpretation Applied By The Sixth Circuit In This Case.. 17

IV. The Healthcare Coverage Landscape Has Improved Significantly Since *Yard-Man* Was Decided 22

CONCLUSION 28

TABLE OF AUTHORITIES

Page(s)

Cases

Aetna Health Inc. v. Davila,
542 U.S. 200 (2004) 2

Allied Chem. and Alkali Workers of Am. v. Pittsburgh Plate Glass Co.,
404 U.S. 157 (1971) 11, 14

AT&T Corp. v. Hulteen,
556 U.S. 701 (2009) 1

Barker v. Kansas,
503 U.S. 594 (1992) 13

Beck v. PACE Int'l Union,
551 U.S. 96 (2007) 1

Bender v. Newell Window Furnishings, Inc.,
681 F.3d 253 (6th Cir. 2012) 18

Bidlack v. Wheelabrator Corp.,
993 F.2d 603 (7th Cir. 1993) 12, 14, 16

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003) 1, 2

Cole v. ArvinMeritor, Inc.,
549 F.3d 1064 (6th Cir. 2008) 20

Conkright v. Frommert,
559 U.S. 506 (2010) 1, 6, 8, 9

Crown Cork & Seal Co. v. Int'l Ass'n of Machinists and Aerospace Workers, AFL-CIO,
501 F.3d 912 (8th Cir. 2007) 12

Federal Express Corp. v. Air Line Pilots Ass'n,
67 F.3d 961 (D.C. Cir. 1995) 9

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989) 1

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987) 8

Gable v. Sweetheart Cup Co.,
35 F.3d 851 (4th Cir. 1994) 12

Gen. Dynamics Land Sys., Inc. v. Cline,
540 U.S. 581 (2004) 1, 2

Golden v. Kelsey-Hayes Co.,
73 F.3d 648 (6th Cir. 1996) 17

Great-West Life & Annuity Ins. Co. v. Knudson,
534 U.S. 204 (2002) 2

Hughes Aircraft Co. v. Jacobson,
525 U.S. 432 (1999) 1

Int'l Union v. ZF Boge Elastmetall LLC,
649 F.3d 641 (7th Cir. 2011) 12

Kennedy v.
Plan Adm'r for DuPont Sav. & Inv. Plan,
555 U.S. 285 (2009) 1, 2

LaRue v. DeWolff, Boberg & Assocs., Inc.,
552 U.S. 248 (2008) 1

Litton Fin. Printing Div. v. NLRB,
501 U.S. 190 (1991) 10, 11, 20, 21

Local Lodge 470 of Dist. 161 v. PPG Indus., Inc.,
No. Civ. 01-22110, 2006 WL 901927
(W.D. Pa. March 31, 2006) 9

Lockheed Corp. v. Spink,
517 U.S. 882 (1996) 1

McCoy v. Meridian Auto. Sys., Inc.,
390 F.3d 417 (6th Cir. 2004) 19

Metropolitan Life Ins. Co. v. Taylor,
481 U.S. 58 (1987) 1, 2

Moore v. Metropolitan Life Ins. Co.,
856 F.2d 488 (2d Cir. 1988) 13, 15, 21

Noe v. PolyOne Corp.,
520 F.3d 548 (6th Cir. 2008) 19, 20

Pease v. Production Workers Union of Chicago & Vicinity Local 707,
386 F.3d 819 (7th Cir. 2004) 9

Rossetto v. Pabst Brewing Co.,
217 F.3d 539 (7th Cir. 2000) 8

Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002) 2, 6

Sereboff v. Mid Atl. Med. Servs., Inc.,
547 U.S. 356 (2006) 2

Smith v. Evening News Ass'n,
371 U.S. 195 (1962) 8

Tarrant Reg'l Water Dist. v. Herrmann,
133 S. Ct. 2120 (2013) 11

UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) 12

UAW v. Yard-Man, Inc.,
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The ERISA Industry Committee (ERIC) and the American Benefits Council (the Council) respectfully submit this brief as *amici curiae* in support of petitioners.[1]

INTEREST OF *AMICI CURIAE*

ERIC is a nonprofit organization representing the Nation's largest employers that maintain ERISA covered pension, healthcare, disability, and other employee benefit plans. These employers provide benefits to millions of active workers, retired persons, and their families nationwide. For this reason, ERIC frequently participates as *amicus curiae* in cases that have the potential for far reaching effects on employee benefit plan design or administration.[2]

The Council is a broad-based nonprofit trade association founded to protect and foster the growth

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[1] Pursuant to this Court's Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amici*, their members, or counsel made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to this Court's Rule 37.3, the parties in this case have granted blanket consent to the filing of *amicus curiae* briefs.

[2] *See, e.g.*, *Conkright v. Frommert*, 559 U.S. 506 (2010) *AT&T Corp. v. Hulteen*, 556 U.S. 701 (2009); *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009); *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248 (2008); *Beck v. PACE Int'l Union*, 551 U.S. 96 (2007); *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

of the Nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Collectively, the Council's approximately 300 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries. The Council also frequently participates as *amicus curiae* in cases that have the potential for far reaching effects on employee benefit plan design or administration.[3]

Amici and their members seek to ensure that voluntary employee benefit plans remain a workable and vital feature of the American employment landscape. When courts interpret collective bargaining agreements to provide lifetime, unalterable healthcare benefits to retirees—in the absence of any language explicitly stating that such benefits were intended to vest for life—many employers may question the wisdom of offering any kind of healthcare benefits to their employees after their retirement date.

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[3] *See, e.g., Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents the question of how to interpret a collective bargaining agreement to determine whether the obligation to provide retiree healthcare benefits survives the agreement's expiration and vests for life. If there is one thing that employers, retirees, and labor unions need in this area of the law, it is certainty. Employers need certainty to conduct their businesses with a clear understanding of whether they will be compelled to provide retirees and their families with decades' worth of healthcare benefits when healthcare treatments, technologies, and drugs are ever-changing. Retirees need certainty to plan their retirement with knowledge of exactly how long any employer-provided coverage will last and whether they might need to explore other options for healthcare coverage both before and after becoming eligible for Medicare. And unions need certainty to effectively engage in collective bargaining with respect to the duration of retiree healthcare benefits.

In light of this collective and overriding need for certainty, this Court should apply the longstanding rule that the benefits and burdens of a contract do not survive the agreement's expiration (and thus do not vest for life) absent a clear and unequivocal statement to the contrary. The cases are legion holding that (1) the benefits and burdens of a contract typically do not survive its expiration absent an express statement of such intent; and (2) contractual silence or ambiguity generally is not read to impose onerous burdens on a party. Because finding that retiree healthcare benefits have vested for life contravenes both of these venerable principles,

courts should—at the very least—require the parties to state their intent to achieve such vesting in clear and unequivocal terms. If the parties wish to negotiate lifetime healthcare benefits for retirees and their families, they are free to do so. But such lifetime benefits should not be a "gotcha" sprung by the judiciary on employers who never intended to assume such costly and unpredictable burdens. Thus, unless clearly stated otherwise, the terms of a collective bargaining agreement pertaining to retiree healthcare benefits should apply only to those employees who retire during the term of the agreement and only for the duration of the agreement.

Requiring parties to state their intentions clearly is all the more appropriate because Congress, in enacting the Employee Retirement Income Security Act of 1974 (ERISA), consciously imposed a vesting standard for *pension* benefits but not *healthcare* benefits. In distinguishing between the two types of benefits, Congress recognized that it is easier for employers to anticipate the costs of pension plans, which are based on fairly stable and predictable data. Healthcare costs, by contrast, are inherently uncertain—new treatments, technologies, and drugs are always emerging, and (as a result) health plan designs, costs, and standards are constantly changing. No reasonable employer can be deemed by *implication* to have unalterably committed itself to provide such uncertain and costly benefits for life.

The Sixth Circuit's contrary rule—that retiree healthcare benefits in a collective bargaining agreement are *presumed* to vest for life—is made up out of whole cloth. Nothing in contract law, labor law, or employee-benefits law supports the notion

that silence regarding a benefit's duration can be interpreted as a promise to provide that benefit for life. And there is no reason to presume that an employer would agree *sub silentio* to such a costly and open-ended commitment. To the contrary, presuming vesting of lifetime retiree healthcare benefits saddles employers with massive, unexpected financial burdens, and leads employers to question the wisdom of providing such benefits at all, for fear that a court might later encumber them with obligations they never intended to assume.

Applying traditional rules of contract interpretation, the judgment below must be reversed because the collective bargaining agreements at issue here do not include a clear and unambiguous statement (or, indeed, any statement at all) of an intent to vest benefits. In finding that retiree healthcare benefits had vested for life, the Sixth Circuit—as it has done in prior cases—relied on a series of special rules of contract interpretation that it has created in this context. Those rules seize upon boilerplate terms of collective bargaining agreements—such as the linking of eligibility for retiree healthcare coverage to eligibility for a pension—to conclude that the parties must have intended to provide lifetime healthcare benefits to retirees. Such strained implications, however, do not remotely qualify as a clear and unequivocal statement that healthcare benefits will vest for life.

Finally, even assuming *arguendo* that it was appropriate for the Sixth Circuit to have relied on policy considerations to support its presumption favoring vesting in *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), such policy considerations have changed dramatically since then. Expansions in

Medicare coverage, as well as the enactment of the Patient Protection and Affordable Care Act and other pathmarking healthcare-related legislation, have created healthcare options that did not exist in 1983. These options ensure that retirees and their families will have access to affordable, comprehensive healthcare coverage even in the absence of the Sixth Circuit's artificial rule that unilaterally imposes lifetime healthcare obligations on employers.

ARGUMENT

I. This Court Should Set Forth Predictable Rules Regarding The Vesting Of Retiree Healthcare Benefits.

It is important to have clear, predictable rules for determining when retiree healthcare benefits will be deemed to have vested for life and thus rendered forever unalterable. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (noting "ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities"); *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (emphasizing, in the pension benefits context, the virtues of a rule that "promotes predictability" and "assure[s] a predictable set of liabilities") (internal quotation marks omitted). That is true for at least three reasons.

First, the lack of a clear rule regarding the vesting of healthcare benefits could burden employers with enormous healthcare costs for which they neither bargained nor are financially prepared. Providing lifetime healthcare benefits to retirees is an incredibly expensive undertaking. Even for a company with a relatively small retiree population, the cost of providing lifetime healthcare benefits can easily exceed tens or hundreds of millions of dollars.

Such costs are substantially higher, of course, for those companies with *hundreds of thousands* of retirees.[4] And those costs will only increase as the retiree population continues to age, life expectancies go up, and increases in healthcare costs continue to outpace inflation and economic growth.[5]

Although some employers might knowingly choose to incur such large and unpredictable costs, the current state of the law creates the possibility that an employer that never agreed or expected to provide lifetime benefits could later be told by a court that benefits did in fact vest and it now is on the hook for hundreds of millions of dollars in unexpected costs. Such enormous, unanticipated costs can have a crippling impact on a company's financial health. *See, e.g., Wood v. Detroit Diesel Corp.*, 607 F.3d 427, 429 (6th Cir. 2010) (CEO testifying that vested retiree healthcare liabilities "could have bankrupted the company by rendering it unable to obtain capital"). At the very least, the prospect that a court could later impose such unexpected costs "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from

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[4] *See, e.g.*, Malcolm Gladwell, Overdrive: Who Really Rescued General Motors, The New Yorker, November 1, 2010, available at http://goo.gl/yLxTpC (noting that, as of 2007, General Motors had around 517,000 retirees).

[5] See United States Census Bureau, An Aging Nation: The older Population in the United States, May 2014, at 1, available at http://www.census.gov/prod/2014pubs/p25-1140.pdf; Deloitte Center for Health Solutions, Health care costs, benefits, and reform: What's the next move for employers?, 2013, at 1, available at http://goo.gl/LW3gJs

adopting them." *Conkright*, 559 U.S. at 517 (internal quotation marks omitted).

Second, without a clear rule specifying when retiree healthcare benefits vest under a collective bargaining agreement and when they do not, employers will again be subject to the same unpredictability and inconsistency concerns that prompted this Court to grant *certiorari* in the first place. *See, e.g.*, *Rossetto v. Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000) (explaining that courts are "all over the lot" in determining whether retiree healthcare benefits in a collective bargaining agreement have vested). Without a clear rule, courts in different jurisdictions will undoubtedly continue to take different approaches and reach different results regarding the vesting of retiree healthcare benefits. Such a patchwork of legal approaches undermines the "congressional policy of having the administration of collective bargaining contracts accomplished under a uniform body of federal substantive law." *Smith v. Evening News Ass'n*, 371 U.S. 195, 200 (1962); *see also Conkright*, 559 U.S. at 517 (2010) (emphasizing that rules in the pension benefit context should "serve[] the interest of uniformity" and "avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions"). It also would "make administration of a nationwide [healthcare] plan more difficult," thus producing "considerable inefficiencies, which the employer might choose to offset by lowering benefit levels." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (relying on this reasoning in the context of applying ERISA's preemption provision to a state law) (internal quotation marks omitted). And it will encourage plaintiffs to forum shop, seeking out those

courts that have construed collective bargaining agreements in manner more favorable to a finding of vesting.

Third, anything short of a clear rule regarding the vesting of retiree healthcare benefits will inevitably lead to more litigation, burdening the courts with disputes that could and should have been resolved at the bargaining table. *See, e.g., Pease v. Production Workers Union of Chicago & Vicinity Local 707*, 386 F.3d 819, 823 (7th Cir. 2004) (noting federal labor law's desire for disputes to be "resolved by the affected parties over the bargaining table [] rather than in court"); *Federal Express Corp. v. Air Line Pilots Ass'n*, 67 F.3d 961, 964 n.4 (D.C. Cir. 1995) ("[C]ollective bargaining, rather than litigation, is the favored mode of settling labor disputes."); *see also* 29 U.S.C. § 201(a). This is not a matter of speculation. For years, the lower federal courts have lamented the seemingly endless stream of retiree healthcare cases that have been spawned by unpredictable and inconsistent legal rules. *See, e.g., Pabst Brewing*, 217 F.3d at 541 (noting that the question of whether retiree healthcare benefits are vested has been "much-litigated"); *Local Lodge 470 of Dist. 161 v. PPG Indus., Inc.*, No. Civ. 01-22110, 2006 WL 901927, *1 (W.D. Pa. March 31, 2006) (noting that "[t]here has been much litigation in this arena in the last fifteen years and copious amounts of 'ink' have been expended" in addressing the duration of retiree healthcare benefits). A clear rule from this Court would help resolve that problem, relieving the courts and the parties from the consequences of contractual uncertainty. *See Conkright*, 559 U.S. at 517 (noting, in the pension benefit context, the virtues of a rule that "promotes efficiency by

encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation").

II. An Intent To Vest Retiree Healthcare Benefits Must Be Stated In Clear And Unambiguous Terms.

In light of the importance of a predictable rule governing the vesting of retiree healthcare benefits, the Court should hold that such benefits vest only when a collective bargaining agreement includes a clear and unambiguous statement that retiree healthcare benefits will be provided for life, notwithstanding the expiration of the applicable collective bargaining agreement. Such a clear-statement rule is consistent with basic principles of contract interpretation, the choices Congress made in enacting ERISA, the nature of healthcare benefits generally, and the purposes of collective bargaining.

The general rule is that contractual obligations included in a collective bargaining agreement terminate upon the expiration of that agreement. *See, e.g., Litton Fin. Printing Div. v. NLRB*, 501 U.S. 190, 207 (1991) (noting that, "in the ordinary course," contractual obligations cease "upon termination of the bargaining agreement").[6] Although parties can

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[6] The National Labor Relations Act, 29 U.S.C. §§ 151 et seq. ("NLRA"), does provide that some obligations continue to apply after the expiration of a collective bargaining agreement as "terms and conditions of employment." 29 U.S.C. § 158(d). This preserves the status quo during bargaining by the union and the employer until there is a new, agreed upon collective bargaining agreement. The surviving "terms and conditions" will cease either when (i) the parties reach a new collective bargaining agreement, or (ii) the parties come to an impasse in bargaining

agree that contractual obligations will persist even after a collective bargaining agreement expires, such an agreement must be stated in "explicit terms." *Id.* (explaining that rights vest "if a collective-bargaining agreement provides in explicit terms that certain benefits continue after the agreement's expiration"). Normal rules of collective-bargaining-agreement interpretation thus counsel in favor of requiring a clear statement before retiree healthcare benefits can be deemed to have vested for life.

Common sense confirms what baseline rules of contract interpretation suggest. As explained above, providing decades' worth of healthcare benefits to retirees is an enormously expensive and unpredictable obligation for a company to assume. It is simply implausible to believe that a company would assume such an extraordinary obligation *sub silentio*. Private parties, like legislatures, typically do not "hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001); *cf. Tarrant Reg'l Water Dist. v. Herrmann*, 133 S. Ct. 2120, 2133 (2013) (if a significant concession is alleged in a contract, "we would expect a clear indication of such [and] not inscrutable silence"). Before imposing such a commitment, courts are

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and the employer choses unilaterally to impose new "terms and conditions." As the statutory text suggests, and this Court has held, those status quo "terms and conditions" apply only to "employees" and do not include benefits provided to retirees. *See Allied Chem. and Alkali Workers of Am. v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971). Retiree healthcare benefits are thus not among the "terms and conditions of employment" that continue to apply even after the expiration of a collective bargaining agreement. *See id.*

entitled and required to insist that it be stated in clear and unequivocal terms. *See, e.g.*, *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 618 (7th Cir. 1993) (Easterbrook, J. dissenting) ("[A]s the duration and cost of the supposed promise increase, so does the level of formality required to conclude that a promise exists."); *Int'l Union v. ZF Boge Elastmetall LLC*, 649 F.3d 641, 648 (7th Cir. 2011) ("Courts are reluctant to interpret contracts providing for some perpetual or unlimited contractual right unless the contract clearly states that that is the intention of the parties.") (internal quotation marks omitted).

That is all the more true given that Congress explicitly considered and *rejected* vesting for healthcare benefits in enacting ERISA. Although that statute contains elaborate vesting requirements for *pension* benefits, those statutory vesting standards do not apply to *healthcare* benefits. *See, e.g.*, *Crown Cork & Seal Co. v. Int'l Ass'n of Machinists and Aerospace Workers, AFL-CIO*, 501 F.3d 912, 919 (8th Cir. 2007); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 138 (3d Cir. 1999); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994). "This was not merely an oversight on the part of Congress." *Skinner Engine*, 188 F.3d at 138. To the contrary, Congress deliberately chose *not* to impose vesting requirements for healthcare benefits because "[t]o require the vesting of those ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income." *Id.* (internal quotation marks omitted). Because Congress deliberately refused to establish a mandatory vesting regime for retiree healthcare benefits, parties seeking to deviate from that baseline in a collective

bargaining agreement should be required to make their intentions clear.

Important differences in the manner in which pension benefits and healthcare benefits are funded also explains why it is far more appropriate to subject the former to vesting standards than the latter. Pension plans are pre-funded by law. That is, employers (and often times employees) fund pension benefits over an employee's career according to regulated actuarial standards designed to ensure that the plan has adequate funding to pay the promised benefits after retirement. *See, e.g.*, *Barker v. Kansas*, 503 U.S. 594, 603 (1992) (recognizing that "a typical pension[] represents deferred compensation"); 29 U.S.C. § 1053(a)(1)(ii) (defining an employee's pension as an "accrued benefit derived from his own contributions" or "from employer contributions"). While there are some exceptions, healthcare plans are (for the most part) funded on a pay-as-you-go basis, meaning that employers incur costs and pay claims as they arise. Thus, whereas companies can predict with a fair degree of accuracy the financial cost of funding a pension plan, healthcare benefits are subject to so many unstable variables that it "prevent[s] accurate prediction of future needs and costs." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). That inability to accurately predict what healthcare costs will be decades into the future, coupled with the fact that healthcare costs are incurred on a pay-as-you-go basis, only confirms that no reasonable employer would agree to provide such benefits in perpetuity without a clear statement of such intent.

The need for national clarity based upon clear and express language is particularly important in this

context because a finding of vested lifetime benefits distorts the collective-bargaining process. The purpose of reoccurring collective bargaining is to allow labor and management regularly to reassess the competitive landscape and make changes as needed to ensure the health of the business and the well-being of employees: "Rational contracting over long periods requires flexibility. What worked yesterday may be counterproductive today. Labor and management need freedom to adapt their arrangement as circumstances change." *Bidlack*, 993 F.2d at 618 (7th Cir. 1993) (Easterbrook, J., dissenting). Finding retiree healthcare benefits to have vested for life, however, ties the hands of labor and management, preventing them from making changes to benefits, coverages, and cost-allocations, even if both sides agree that such changes make sense. The financial burdens of vesting can also prevent employers and unions from agreeing to new benefits for *active* employees, thus directly impacting a union's ability to obtain improvements that its membership might otherwise be able to get if retiree healthcare benefits were not locked into place. By insisting on express vesting language, courts can ensure that the parties really intended to tie their own hands before a court hamstrings the negotiating freedom that would otherwise exist.[7]

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[7] Although retirees typically are not part of the "bargaining unit" for whom unions negotiate, employers and unions can, if they so choose, negotiate and agree to terms in a collective bargaining agreement providing healthcare benefits to existing retirees. *See, e.g.*, *Pittsburgh Plate Glass*, 404 U.S. at 170-73. In the absence of vesting, therefore, employers and unions have a free hand to adjust retiree healthcare benefits to respond to evolving business realities. A finding of vesting, in contrast,

Additionally, vesting in the context of healthcare benefits would mean that retirees would be locked into a single set of treatments, services, and medications—because employers could not be deemed to have consented to covering treatments and medications that did not ever exist at the time the collective bargaining agreement was ratified. But healthcare plans are "subject to fluctuating and unpredictable variables," including "inflation, changes in medical practice and technology, and increases in the cost of treatment." *Moore*, 856 F.2d at 492. Doctors and insurance providers come and go. Medical technologies and practices evolve over time. And healthcare plans change from year to year. No plan administrator or participant wants to be locked into a single plan, or a single set of services, or even a single kind of coverage, which may no longer be relevant, appropriate, or preferred over the years. Instead, it is in everyone's interests—retirees included—for healthcare benefits to evolve over time as treatments and delivery mechanisms change. In light of that inherent need for flexibility, the vesting of retiree healthcare benefits is not something that should be inferred in the absence of a clear statement of intent that the parties actually did intend to be locked into a single set of services or level of medical coverage.

None of this is to say, of course, that an employer cannot commit to providing lifetime healthcare benefits to retirees if it affirmatively chooses to do so (and in the manner it chooses to do so). But in light

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locks employers and unions into a set of benefits that cannot be changed, even if circumstances shift dramatically.

of traditional rules of contract interpretation, Congress' deliberate decision not to subject healthcare benefits to ERISA's vesting regime, the significance (both in terms of duration and costs) of finding benefits to be vested, and the nature of collective bargaining, parties must at the very least state their intent to vest benefits in express and unequivocal terms. Mere silence regarding the duration of those benefits—or even unclear or ambiguous language—cannot be enough to trigger such a significant obligation: "It unsettles and in the end disserves the institution of voluntary agreement to permit straws in the wind to become shackles." *Bidlack*, 993 F.2d at 618 (Easterbrook, J. dissenting).

Finally, recognizing that collective bargaining agreements typically do not provide for vested healthcare benefits (absent a clear statement of an unequivocal intent to do so) will not automatically result in scores of employers terminating retiree healthcare plans. Employers have strong incentives to offer healthcare benefits to their employees and retirees, including the need to attract and retain skilled workers and maintain good relationships with unions and employees. That is precisely why most employers offer healthcare benefits to their salaried, non-collectively-bargained employees, even though those employers have no legal or contractual obligation to do so. Employers will thus continue to offer and provide healthcare benefits to their retiree populations where it makes business sense to provide such benefits, without being compelled to do so by the Sixth Circuit's artificial vesting rule.

III. The Court Should Expressly Reject The Flawed Rules Of Contract Interpretation Applied By The Sixth Circuit In This Case.

When proper rules of contract interpretation are applied, the judgment below must be reversed because the contracts in this case did not include a clear and unequivocal statement that the parties intended to vest retiree healthcare benefits for life. In reaching a contrary conclusion, the Sixth Circuit again applied a special body of contract law that it has developed in this context to find a "clear and unambiguous" intent to vest benefits where none exists. Those rules of interpretation help explain why the Sixth Circuit has "concluded that benefits have vested (or likely vested) in 16 out of 18 reported cases" since 1983, Pet. 12, while simultaneously purporting to disclaim the application of the *Yard-Man* presumption in favor of vesting, *see, e.g.*, *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571, 579 (6th Cir. 2006); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 656 (6th Cir. 1996).

This Court should expressly reject the Sixth Circuit's reliance on neutral or ambiguous contract provisions to find vesting of lifetime retiree healthcare benefits. Contrary to the Sixth Circuit's reasoning, the provisions discussed below do not and cannot suggest an intent to extend retiree healthcare benefits beyond the expiration date of a collective bargaining agreement.[8]

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[8] The Sixth Circuit's rule also ignores that many plans clearly state that the employer is reserving the right to modify or terminate the plan in the future. Such plans, which often are incorporated by reference into the collective bargaining agreement itself, cannot be deemed to create vested benefits,

Full Premium/Contribution. The Sixth Circuit often holds (as it did in this case) that use of phrases such as "full premium," "full contribution," or "full cost" to describe a company's retiree healthcare obligation indicates that the parties intended for those benefits to vest for life. *See, e.g.*, Pet. App. 11 (relying on the phrase "full Company contribution" to find vesting); *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 262 (6th Cir. 2012) (relying on phrase "[t]he Company agree[s] to pay the cost of [healthcare] insurance for the retiree and his dependents" to find vesting) (internal quotation marks omitted). Such promises, the Sixth Circuit has reasoned, would be "illusory" if a company could "unilaterally change the level of contribution" after the contract's expiration. Pet. App. 11.

That makes no sense. A company's promise to pay the "full premium" of retiree healthcare benefits specifies the amount the company has agreed to contribute *during the term of the contract*; it does not at all suggest that the company has agreed to continue to pay that amount for retirees *after the contract has expired*. Nor is there anything "illusory" about such a promise. A commitment to pay the "full premium" of retiree healthcare is a fully enforceable obligation while the collective bargaining agreement is in effect. The fact that such an obligation—like most other provisions of a collective bargaining agreement—ceases to apply as a contractual obligation once the contract expires does not render that promise "illusory."

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given the employer's clearly stated intention to reserve all rights.

Tying of Eligibility for Pension & Healthcare Benefits. The Sixth Circuit in this case also held (as it has in countless prior cases) that the parties must have intended to vest retiree healthcare benefits because the applicable collective bargaining agreements "tied *eligibility* for health-care benefits to pension benefits." Pet. App. 12 (emphasis added); *see also, e.g., Noe v. PolyOne Corp.*, 520 F.3d 548, 558 (6th Cir. 2008) ("According to this court, language in an agreement that ties eligibility for retiree health benefits to eligibility for a pension indicates an intent to vest the health benefits."); *McCoy v. Meridian Auto. Sys., Inc.*, 390 F.3d 417, 422 (6th Cir. 2004) ("Because the Supplemental Agreement ties eligibility for retirement-health benefits to eligibility for a pension ... there is little room for debate that the retirees' health benefits vested upon retirement.").

But such cross-referencing of eligibility requirements says nothing at all about whether the parties agreed to lifetime healthcare benefits for retirees. By stating that benefits will be provided to those "who are eligible for and receiving a monthly pension," Pet. App. 6, or to those who are "eligible for benefits under ... [the] Pension Plan," *McCoy*, 390 F.3d at 419, the parties are simply identifying *who* will receive healthcare benefits; they are not saying anything about the *duration* of that benefit. For that reason, the prototypical language on which the Sixth Circuit relies to find vesting affords healthcare benefits to those individuals "*who* are eligible" for a pension, Pet. App. 6 (emphasis added), not to individuals "*so long as*" they receive a pension. There is, moreover, a straightforward reason why employers apply the same eligibility rules for pensions and healthcare benefits, and that reason has nothing at

all to do with vesting or duration: corporate benefits departments simply find it easier to administer post-retirement benefits, including healthcare and pension plans, if there is a commonality with respect to eligibility.

General Durational Clauses. The Sixth Circuit also consistently holds that a general durational clause in a collective bargaining agreement—*e.g.*, the provision stating that the contract will expire on a date certain—is not sufficient to terminate retiree healthcare benefits at the conclusion of that agreement. *See, e.g.*, *Noe*, 520 F.3d at 554 ("[A]bsent specific durational language referring to retiree benefits themselves, courts have held that the general durational language says nothing about those retiree benefits.") (internal quotation marks omitted); *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, 1071 (6th Cir. 2008) ("[T]he rule in this circuit [is] that general durational clauses cannot trump contractual promises of lifetime retiree healthcare benefits."); *Yolton*, 435 F.3d at 580 ("[G]eneral durational provisions only refer to the length of the [collective bargaining agreements] and not the period of time contemplated for retiree benefits." (internal quotation marks omitted)).

Again, that is wrong. As explained, contractual obligations included in a collective bargaining agreement generally terminate upon the agreement's expiration. *See Litton*, 501 U.S. at 207. There is nothing in law or logic that carves out an exception to that general rule for retiree healthcare benefits. To the contrary, although the NLRA mandates that "terms and conditions of employment" must survive the expiration of a collective bargaining agreement in certain circumstances, retiree healthcare benefits are

not among such terms and are instead treated as ordinary "contractual obligations" that "cease[], in the ordinary course, upon termination of the bargaining agreement." *Id.*

Specific Durational Clauses. Finally, the Sixth Circuit also has "consistently held that the inclusion of specific durational limitations in some provisions, but not others, suggests that benefits not so specifically limited, were intended to survive." *Moore v. Menasha Corp.*, 690 F.3d 444, 458 (6th Cir. 2012) (internal quotation marks omitted). That too reflects a flawed understanding of how collective bargaining agreements typically are drafted.

Specific durational clauses operate to terminate certain contractual obligations before the date on which the collective bargaining agreement terminates as a whole—if, for example, certain events occur or if an earlier time period is reached. The choice to attach such language to specific contractual obligations, however, hardly suggests that all other obligations not so limited were intended to survive in perpetuity. The parties' failure to include specific language terminating retiree healthcare benefits on a specific date thus does nothing to suggest that the parties intended for those benefits to survive the expiration of the contract and vest for life.

To conclude, the Sixth Circuit has used these false rules of interpretation to impose in fact what it has disclaimed in form—a presumption in favor of vesting that finds an intent to permanently vest benefits from language that suggests nothing of the sort. This Court should expressly reject those rules.

IV. The Healthcare Coverage Landscape Has Improved Significantly Since *Yard-Man* Was Decided.

Finally, dramatic improvements in the availability and affordability of healthcare options for retirees provide yet another reason to reject the Sixth Circuit's artificial rule presuming that healthcare benefits vest for life.

Yard-Man was decided at a time when retirees—especially pre-65 retirees who were not yet eligible for Medicare—faced significant obstacles to obtaining non-employer-provided healthcare coverage. Access to affordable individual healthcare plans was limited. Exclusions for pre-existing medical conditions (even under a spouse's employer-provided plan) often resulted in inadequate coverage. And retirees had few protections under federal law that would guarantee a baseline level of coverage or require private insurers to issue affordable plans.

Although the so-called *Yard-Man* presumption could not be legally justified even under that regime, any policy considerations that may have existed when it was first applied no longer exist. Since *Yard-Man* was decided in 1983, a number of legal changes have significantly expanded the availability and affordability of healthcare benefits for both pre-65 and post-65 retirees. Those legal changes have dramatically shifted the landscape for post-employment healthcare benefits and undermined the policy considerations (if any) that originally supported the *Yard-Man* presumption.

With respect to pre-65 retirees, Congress has enacted a number of statutes over the past 30 years that have increased access to healthcare coverage for

retirees who are not yet eligible for Medicare. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), expanded the availability and breadth of health plans available to retirees who lost coverage. Pub. L. No. 104-191, 110 Stat. 1936 (1996). In particular, HIPAA eliminated (or greatly restricted) insurability rules, pre-existing condition limitations, and enrollment rules that previously had worked to deny coverage to retirees who, after losing their own coverage, then sought coverage under a spouse's employer health plan. *See, e.g., id*, title I, §§ 701-702; *see also* 29 U.S.C. § 1182. HIPAA also required employer group health plans to give special enrollment opportunities to a covered employee's dependents (including a spouse) who lost coverage under another plan. *See* 29 U.S.C § 1181. Thus, under HIPAA, a retiree who loses coverage under an employer's plan is automatically provided an opportunity to enroll in coverage under his or her spouse's group health plan, with no (or few) restrictions for pre-existing conditions.

Congress and the Internal Revenue Service have also created funding arrangements that give employers and employees innovative ways to provide retiree health coverage. Two of these innovations—Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs)—permit employers (in the case of HRAs) or employers and employees (in the case of HSAs) to make tax-favored contributions towards the cost of retiree medical care. *See* IRS Notice 2002-45; IRS Rev. Rul. 2002-41; Pub. L. No. 108-173, 117 Stat. 2066 (2003).

In general, these arrangements allow for tax-favored contributions that can be used by active or retired employees to cover healthcare expenses in the

current year or rolled over for use in future years. Because the balances in HRAs and HSAs roll over from year to year—and, in the case of HRAs, accumulate earnings on a tax-free basis—these arrangements are valuable tools for offsetting the cost of retiree medical care for both employers and retirees. They also provide retirees with greater flexibility, permitting them to purchase insurance that is tailored to their particular needs (as opposed to the traditional model in which the insurance design is decided for them).

And the most-significant change for pre-65 retirees in the past 30 years has been the enactment of the Patient Protection and Affordable Care Act (ACA). Pub. L. No. 111–148, 124 Stat. 119 (2010). The ACA is comprised of the Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152, 124 Stat. 1029). In general, the ACA requires insurance companies to sell insurance to everyone regardless of their health status. The ACA accomplishes that goal by (1) prohibiting insurers from denying coverage to individuals due to pre-existing conditions, *see* Pub. L. No. 111-148 at § 2704; (2) requiring insurers to offer the same premium price to all applicants of the same age and geographic location, *see id.* § 2701; (3) providing subsidies so that most low- and middle-income individuals (*i.e.*, those with income below 400% of the federal poverty level) can receive no- or low-cost insurance, *see id.* § 1401; (4) imposing minimum-coverage standards and other policy enhancements; (5) precluding the termination of coverage because of a person's health; and (6) first limiting and ultimately eliminating plan provisions that impose annual or lifetime limits on benefits. *See*

Focus on Health Reform, *Summary of the Affordable Care Act*, The Henry J. Kaiser Family Found., April 23, 2013, available at http://goo.gl/Z5qnT. In addition, the ACA establishes federal and state marketplaces through which individuals (and their families) can readily access quality insurance. *See* Pub. L. No. 111-148 at §§ 1301-04.

The reforms implemented by the ACA have redefined the healthcare coverage landscape in a manner that is worlds apart from what existed when *Yard-Man* was decided. In 1983, a pre-65 retiree who lost coverage through his employer would have had a difficult time finding replacement coverage at an affordable price, particularly if he suffered from a pre-existing medical condition. Now, health insurers *must* offer high-quality healthcare coverage to retirees at affordable rates without regard to pre-existing medical conditions. The availability of federal subsidies, moreover, helps defray costs even further for those pre-65 retirees earning between 100% and 400% of the federal poverty level. For example, a retired couple who are both 61 years old with household income of $60,000 per year will pay a premium of no more than $5,700 per year ($475 per month) for high-quality health insurance. *See* Health Reform Subsidy Calculator, The Henry J. Kaiser Family Found, available at http://goo.gl/WLjzU.

In addition, Congress also has greatly expanded healthcare options for post-65, Medicare-eligible retirees. Even in 1983, Medicare-eligible retirees enjoyed baseline coverage under Parts A and B of the Medicare Act, which paid for (among other things) hospital care, doctor visits, medical equipment, laboratory and diagnostic services, preventive care, outpatient care, and home healthcare. *See*

Medicare.gov, *What Does Medicare Part A Cover*, available at http://goo.gl/tbO27; *see also id.*, *What Does Medicare Part B Cover*, available at http://goo.gl/ec4pBi.

As part of the Balanced Budget Act of 1997, however, Congress adopted a new Medicare-coverage option, known as "Part C," that significantly expanded the healthcare options available to Medicare-eligible retirees. *See* 42 U.S.C. §§ 1395w-21-29. Part C plans (now referred to as Medicare Advantage Plans) are offered by private insurance companies that receive compensation from the federal government. In general, Medicare Advantage Plans greatly reduce the amount of out-of-pocket expenses that a retiree is required to pay and may offer significantly broader benefit options than basic Medicare, such as dental, vision, hearing and/or health and wellness programs. *See* Medicare.gov, *Medicare Advantage Plans cover all Medicare Services* available at http://goo.gl/bS2ePZ. According to the Kaiser Family Foundation, the utilization of Medicare Advantage Plans continues to grow rapidly, with almost one out of every three Medicare-eligible individuals enrolled in a Medicare Advantage Plan. *See* Marsha Gold, *et al.*, *Medicare Advantage 2014 Spotlight: Enrollment Market Update*, The Henry J. Kaiser Family Found., (April 2014), available at http://goo.gl/qD6IkO.

Moreover, Congress created an entirely new prescription drug program for Medicare-eligible retirees, referred to as Medicare Part D. 42 U.S.C. §§ 1395w-101-154. Part D went into effect in 2006 and guarantees retirees access to affordable and comprehensive prescription drug coverage. Medicare-eligible retirees can obtain their Part D coverage by

joining private, standalone prescription drug plans or by joining a public Medicare Part C Plan (discussed above) that offers prescription drug coverage. *See* Medicare.gov, *What is Medicare?* available at http://goo.gl/mqpfvb. In 2010, Congress expanded Part D coverage and reimbursements further by including a provision in the Affordable Care Act to close a coverage gap, known as the "donut hole." *See* http://goo.gl/ZwsfcD. Thus, unlike retirees in 1983, post-65 retirees today enjoy robust prescription drug coverage under Medicare Part D.

By themselves, these Medicare programs offer post-65 retirees sound and affordable health insurance. For those post-65 retirees who wish to purchase coverage that supplements Medicare, however, there has developed over time a wide array of Medicare supplement plans also known as "Medigap" insurance. Medigap policies offer retirees an affordable way to cover certain healthcare costs that are not covered by traditional Medicare. Over the past 30 years, federal legislation has fostered the development of Medigap policies, making those policies more affordable and more widely available than when *Yard-Man* was decided. *See, e.g.*, The Medicare and Medicaid Patient Program Protection Act of 1987 (Pub. L. No. 100–93, 101 Stat. 680 (1987)) (imposing criminal sanctions on anyone making false claims with respect to the sale of a Medigap policy); The Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100–203, 101 Stat. 1330 (1987)) (allowing participating physicians and other health care providers and vendors to be paid directly by Medigap plans); The Medicare Catastrophic Coverage Act of 1988 (Pub. L. No. 100–360, 102 Stat. 683 (1988)) (directing the Department of Health and Human

Services to establish protocols for retirees to obtain information about their Medigap insurer and requiring Medigap plans to meet or exceed national healthcare guidelines); The Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101–508, 104 Stat. 1388 (1990)) (standardizing Medigap plans, imposing guaranteed plan renewability, curtailing the use of pre-existing condition limitations and other forms of health-based pricing, and requiring insurers return benefits to policyholders that amount to at least 75% of the aggregate premium amount); Balanced Budget Act of 1997 (Pub. L. No. 105–33, 111 Stat. 251 (1997)) (introducing more protections for retirees by limiting pre-existing condition exclusions); The Consolidated Appropriations Act, 2001 (Pub. L. No. 106–554, 114 Stat. 2763 (2000)) (prohibiting certain discriminatory practices in Medigap plans); The Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110–275, 122 Stat. 2494 (2008)) (establishing enhanced benefits standards for Medigap Plans).

These and other statutes show the great lengths to which the Federal Government has gone over the past 30 years to expand and enhance the healthcare options available to retirees. Today, both pre-65 and post-65 retirees enjoy many options for obtaining comprehensive healthcare coverage that were unavailable when the Sixth Circuit decided *Yard-Man* in 1983, thereby rendering obsolete any policy considerations underlying the *Yard-Man* presumption (which was legally unjustifiable from the outset).

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment.

July 24, 2014

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AMICUS CURIAE BRIEF

RECORD AND BRIEFS

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IN THE

Supreme Court of the United States

M&G POLYMERS USA, LLC, *et al.*,
Petitioners,

v.

HOBERT FREEL TACKETT, *et al.*,
Respondents.

On Writ of Certiorari to the United States Courts of Appeals for the Sixth Circuit

BRIEF OF AMICUS CURIAE

FOX RETIREE COMMITTEE
GOLDEN RETIREE COMMITTEE
YOLTON RETIREE COMMITTEE

IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether collectively bargained promises of retiree healthcare should be construed in the same manner as all contracts – to ascertain and enforce the actual intent of the contracting parties?

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
I. INTEREST OF THE AMICUS CURIAE	1
II. SUMMARY OF ARGUMENT	2
III. ARGUMENT	3
A. The History of Collectively Bargained Retiree Health Care	3
B. The Function of Courts In Contract Cases Is To Ascertain And Enforce the Parties' Original Intent	6
C. ERISA Provides No Guidance On Contractual Intent	11
D. Retiree Health Care Litigation in the Sixth Circuit	13
1. *Golden v. Kelsey-Hayes Co.*	15
2. *Fox v. Massey-Ferguson, Inc.*	21
3. *Gilbert v. Doehler-Jarvis, Inc.*	25
4. *Yolton v. El Paso Tennessee Pipeline Co*	31
IV. CONCLUSION	37

TABLE OF AUTHORITIES

CASES: Page

Boston Sand & Gravel Co. v. United States, 278 U.S. 41 (1928) 9

Bradley v. Washington, Alexandria & Georgetown Steam Packet Co., 38 U.S. 89 (1839) 6

Brooklyn Life Ins. Co. v. Dutcher, 95 U.S. 269 (1877) 9

Carbon Fuel Co. v. Mine Workers, 444 U.S. 212 (1979) 12

Chemical Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971) 13

Chesapeake & Ohio Canal Co. v. Hill, 82 U.S. 94 (1872) 7

Cole v. ArvinMeritor, Inc., 516 F. Supp. 2d 850 (E.D. Mich. 2005) 14

Cole v. ArvinMeritor, Inc., 515 F. Supp. 2d 791 (E.D. Mich. 2006), *aff'd*, 549 F.3d 1064 (6th Cir. 2008) 14

Davison v. Von Lingen, 113 U.S. 40 (1885) ... 7

Fox v. Massey-Ferguson, Inc., 172 F.R.D. 653 (E.D. Mich. 1995), *aff'd*, 91 F.3d 143 (6th Cir. 1996) 14, 21, 24

TABLE OF AUTHORITIES—Continued

	Page
Fox v. Massey-Ferguson, Inc., 2009 U.S. Dist. LEXIS 118404, 48 Emp. Ben. Cases (BNA) 1737 (E.D. Mich. 2009)	1
Fox v. Massey-Ferguson, Inc., 2008 U.S. Dist. LEXIS 100481 (E.D. Mich. 2008)	1
George v. Tate, 102 U.S. 564 (1881)	7
Gilbert v. Doehler-Jarvis, Inc., 87 F. Supp. 2d 788 (N.D. Ohio 2000)	14, 30
Golden v. Kelsey-Hayes Co., 73 F.3d 648 (6th Cir. 1996), *cert. denied*, 519 U.S. 807	14
Golden v. Kelsey-Hayes Co., 845 F. Supp. 410 (E.D. Mich. 1994), *aff'd* 73 F.3d 648 (6th Cir. 1996)	14, 15
Golden v. Kelsey-Hayes Co., 954 F. Supp. 1173 (E.D. Mich. 1996)	15, 20
Inter-Modal Rail Employees Ass'n v. Atchison, Topeka. & Santa Fe Ry., 520 U.S. 510 (1997)	12
Joyce v. Curtiss-Wright Corp., 171 F.3d 130 (2d Cir. 1999)	11
Old Colony Trust Co. v. City of Omaha, 230 U.S. 100 (1913)	9

TABLE OF AUTHORITIES—Continued

	Page
Pittsburgh Plate Glass Co. v. NLRB, 427 F.2d 936 (6th Cir. 1970), *aff'd sub nom Chemical Workers v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971)	4, 12
Schonholz v. Long Island Jewish Medical Center, 87 F.3d 72 (2d Cir. 1996)	11
Steelworkers v. American Manufacturing Co., 363 U.S. 564 (1960)	2, 8
Steelworkers v. Enterprise Wheel & Car Corp., 363 U.S. 593 (1960)	2
Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574 (1960)	2, 8
Textile Workers v. Lincoln Mills, 353 U.S. 448 (1957)	4, 8
Towne v. Eisner, 245 U.S. 418 (1918)	7
UAW v. Skinner Engine Co., 188 F.3d 130 (3d Cir. 1999)	10, 11
UAW v. Yard-Man, Inc., 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984)	4, 5, 6
United States v. American Trucking Ass'ns, 310 U.S. 534 (1940)	9

TABLE OF AUTHORITIES—Continued

Page

United States v. Witkovich,
353 U.S. 194 (1957)..... 9

Upholsterers v. American Pad & Textile Co.,
372 F.2d 427 (6th Cir. 1967)..... 4, 12

Williams v. Fenix & Scission, Inc.,
608 F.2d 1205 (9th Cir. 1979)..... 7

Yolton v. El Paso Tennessee Pipeline Co.,
435 F.3d 571 (6th Cir. 2006), *cert. denied*, 549 U.S. 1019..... 14

Yolton v. El Paso Tennessee Pipeline Co.,
318 F. Supp. 2d 455 (E.D. Mich. 2003), *aff'd*, 435 F.3d 571 (6th Cir. 2006)..... 14, 31, 36

Yolton v. El Paso Tennessee Pipeline Co.,
2008 U.S. Dist. LEXIS 17619
(E.D. Mich. 2008) 37

FEDERAL STATUTES

Labor Management Relations Act of 1947

29 U.S.C. §185 ..... 4, 12, 13

Employee Retirement Income Security Act of 1974

29 U.S.C. §1001 ..... 11, 13

29 U.S.C. §1144(d)..... 12

I. INTEREST OF THE AMICUS CURIAE [1]

The *Fox*, *Golden* and *Yolton* Retiree Committees, formed as a result of class action settlement agreements, submit this brief as amicus curiae in support of respondents.[2] The settlement agreements, reached after years of litigation, provide for fully paid, lifetime retiree health care benefits for retirees and surviving spouses.[3] The basic legal issue in each case was whether the employer had promised in collective bargaining agreements (CBAs) to provide lifetime health care benefits for retirees and surviving spouses.

The Retiree Committees submit this brief because they are concerned that other retirees may lose their contractual entitlement to lifetime healthcare benefits. Imposing a "clear statement" requirement as advocated by petitioners and their amicus curiae would

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[1] This Brief was authored entirely by undersigned counsel. No person or entity other than undersigned counsel made a monetary contribution to the preparation or submission of this Brief.

[2] The *Fox* Retiree Committee was established under the 1998 Settlement Agreement in *Fox v. Massey-Ferguson* to administer that agreement. The *Golden* Retiree Committee was established for the same purpose under the 2000 Settlement Agreement that concluded *Golden v. Kelsey-Hayes*. The *Yolton* Retiree Committee was established under the 2011 Settlement Agreement in *Yolton v. El Paso Tennessee Pipeline Co.*

[3] Over the years, the *Fox* and *Golden* Retiree Committees have enforced the rights of retirees and surviving spouses to healthcare benefits provided by those Settlement Agreements *See, e.g., Fox v. Massey-Ferguson, Inc.*, 2009 U.S. Dist. LEXIS 118404, 48 Emp. Ben. Cases (BNA) 1737 (E.D. Mich. 2009) and 2008 U.S. Dist. LEXIS 100481 (E.D. Mich. 2008)

foreclose full judicial inquiry into the actual intent of the contracting parties, contrary to traditional rules of contract interpretation.

II. SUMMARY OF ARGUMENT

Most often, when unionized employers agreed to lifetime retiree healthcare benefits in the 1960s and 1970s, they did so in CBAs that did not use the words *lifetime* or *vested*. Despite the absence of such "clear" terms, as this brief shows, retirees in the ensuing decades have conclusively proved, and courts have rightly held, that employers unequivocally intended to promise lifetime retiree healthcare benefits.

Petitioners and their allied amicus curiae ask the Court to impose a "clear statement" requirement; that is, that unless a CBA contains certain "magic words" like *lifetime* or *vested*, courts must rule in the employer's favor. This rigid rule is contrary to the traditional rules of contract interpretation that have guided the judiciary since courts first began enforcing private contracts. It is also contrary to the practicality and flexibility applied under federal labor law to the enforcement of collectively bargained contracts reflected in the *Steelworkers Trilogy*.[4]

If a "clear statement" rule had been applied to the four cases discussed below, the definitive evidence of the employers' actual intent might have been deemed inadmissible. Employers would have evaded their

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[4] *Steelworkers v. American Manufacturing Co.*, 363 U.S. 564 (1960); *Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574 (1960); *Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 593 (1960).

promises and thousands of retirees would have been deprived of the benefit of their bargain, earned by decades of industrial labor. That did not happen because the courts applied traditional rules of contract interpretation to determine the employers' intent, rejecting the rigidity of the "clear statement" rule proposed by petitioners.

The Retiree Committees urge the Court to retain the traditional rules of contract interpretation. Under these rules, courts consider contract terms, contractual context, admissions, the parties' conduct and other probative evidence of the parties' actual intent. These time-tested rules should not be eroded to provide special treatment to employers at the expense of the historical function of courts or of retirees seeking to enforce employer promises.

III. ARGUMENT

A. The History of Collectively Bargained Retiree Healthcare

Collectively bargained retiree healthcare dates back at least fifty years. During the 1960s and early 1970s, coincident with the 1965 enactment of Medicare, private sector employers and industrial unions regularly negotiated promises of lifetime, employer paid retirement healthcare benefits in collective bargaining. Employers saw promising retiree healthcare as a good idea. It helped attract and retain qualified employees; retiree healthcare was not costly, especially because employers traded it for reduced wages for active employees; there were more active workers and fewer retirees; and retirements did not start as early or last as long.

In the intervening years, circumstances changed. Globalization, technology, increased life expectancy, new accounting standards, mergers and acquisitions, medical inflation, economic recessions and other systemic factors have made healthcare obligations harder to keep and provided the incentive for employers to break their longstanding promises.

The Sixth Circuit first construed CBAs promising vested retiree welfare benefits shortly after those promises were made. In *Upholsterers v. American Pad & Textile Co.*, 372 F.2d 427 (6th Cir. 1967), the Sixth Circuit held that a CBA provided vested retiree life insurance benefits. In *Pittsburgh Plate Glass v. NLRB*, 427 F.2d 936, 947 (6th Cir. 1970), *aff'd sub nom Chemical Workers v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971), the Sixth Circuit addressed collectively bargained retiree healthcare promises:

> Once retirement benefits have been bargained for, earned and become payable, the employer may not recant on his contractual obligations to pay them. Section 301, Labor Management Relations Act, 1947, 29 U.S.C. §185(a)(1964).

It was in this historical context that the Sixth Circuit decided *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984). The Sixth Circuit relied on traditional contract principles for interpreting collectively bargained promises of retiree health care. Whether those benefits vest depends on the intent of the contracting parties. Citing *Textile Workers v. Lincoln Mills*, 353 U.S. 448, 457-58 (1957), the court noted that "substantive federal law" developed under Section 301 of the Labor Management Relations Act of 1947, 29 U.S.C. § 185, governs.

716 F.2d at 1479. "However, traditional rules for contractual interpretation are applied as long as their application is consistent with federal labor policies." *Id.* A "court should first look to the explicit language of the [CBA] for clear manifestations of intent," remembering that "even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion." *Id.* Each CBA provision should be interpreted "consistently with the entire document and the relative positions and purposes of the parties." *Id.* CBAs should be construed to render no terms "nugatory" and to "avoid illusory promises." *Id.* at 1480. Where ambiguities exist, the court "may look to other words and phrases in the [CBA] for guidance" in clarifying ambiguous durational provisions relating to retiree benefits. *Id.*

Applying these principles, the Sixth Circuit agreed with the district court that the CBA provided for lifetime retiree health benefits. *Id.* It then examined the context in which retiree benefits arose, noting that under federal labor law, retiree benefits are a permissive subject of bargaining. *Id.* at 1482. It was "unlikely that such benefits, which are typically understood as a form of delayed compensation," would be left to "the contingencies of future negotiations." *Id.* The court referred to retiree benefits as "status" benefits that carry an inference that they last as long as the prerequisite status – retirement – lasts, that is, for life. *Id.* Retiree healthcare benefits are not "interminable" by nature: "Rather, as part of the context from which the collective bargaining agreement arose, the nature of such benefits simply provides another inference of intent." *Id.* While this "inference" alone cannot prove inter-

minable benefits, this "contextual factor buttresses the already sufficient evidence of such intent in the language" of the CBA. *Id.*

Yard-Man was decided on the CBA language alone. *Id.* at 1478. Neither party introduced extrinsic evidence of the contracting parties' intent. The language of the CBA, not the *Yard-Man* "inference," was the basis of the court's decision that retiree healthcare vested. The inference was simply a "buttress," drawn from the context of federal labor law and the collective bargaining process, confirming the court's interpretation of the CBA. *Id.*

Retirees did not, and did not need to, rely on any "inference" in the four cases surveyed below. The evidence of employer intent submitted to the district court was overwhelming and unequivocal. As in many other cases, the retirees proved their entitlement to "lifetime" benefits by conclusively showing, under the traditional rules of contract interpretation, that this is precisely what the contracting employer intended.

B. The Function Of Courts In Contract Cases Is To Ascertain And Enforce The Parties' Original Intent

The "cardinal rule" of contract interpretation has always been that a court must first ascertain and then enforce the intention of the contracting parties. In *Bradley v. Washington, Alexandria & Georgetown Steam Packet Co.*, 38 U.S. 89, 97 (1839), the Court wrote:

> It is a principle recognised and acted upon by all Courts of justice, as a cardinal rule in the construction of all contracts, that the intention of the par-

> ties is to be inquired into; and if not forbidden by law, is to be effectuated.

Accord George v. Tate, 102 U.S. 564, 570 (1881) ("intent of the parties is the contract, and whenever that is ascertained, however inartificially [sic] expressed, it is the duty of courts to give it effect"). In *Chesapeake & Ohio Canal Co. v. Hill*, 82 U.S. 94, 99-100 (1872), the Court stated:

> [W]e should look carefully to the substance of the original agreement . . . as contradistinguished from its mere form, in order that we may give it a fair and just construction, and ascertain the substantial intent of the parties, which is the fundamental rule in the construction of all agreements.

Contracts must be interpreted and enforced according to the parties' intent when the contract was made, irrespective of subsequent events. *Davison v. Von Lingen*, 113 U.S. 40, 50 (1885). Words contracting parties use to express their agreement must be viewed according to their contemporaneous meaning. Justice Holmes wrote in *Towne v. Eisner*, 245 U.S. 418, 425 (1918):

> A word is not a crystal, transparent and unchanged, it is the skin of a living thought and may vary greatly in color and content according to the circumstances and the time in which it is used.

Judge, now Justice, Kennedy, concurring in *Williams v. Fenix & Scission, Inc.*, 608 F.2d 1205, 1210-11 (9th Cir. 1979), rejected the concept that judicial inquiry into the contractual intent could be short-circuited by a so-called "plain meaning" approach:

> This approach to contractual interpretation has been rejected by the circuit and it is out of line with the better-reasoned contract law cases. It results in the exclusion of evidence clearly probative of the parties' understanding of their obligations. Examination of the circumstances which gave rise to the agreement, and of the subsequent acts and communications which bear on the parties' intent at the time of contracting, are relevant to show the intended meaning of a provision in a contract.

While traditional rules of contract interpretation generally apply to CBAs, they are not traditional contracts. CBAs are negotiated in unique circumstances and assessed in the broader context of federal labor policy. *Textile Workers v. Lincoln Mills*, 353 U.S. 448, 457 (1957); *Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574, 579-82 (1960). But, the goal of all contract interpretation, including the interpretation of CBAs, is the same – to ascertain and enforce the intent of the contracting parties through analysis of all available evidence.

Justice Brennan, concurring in *Steelworkers v. American Manufacturing Co.*, 363 U.S. 564, 570, (1960), wrote:

> Words in a collective bargaining agreement, rightly viewed by the Court to be the charter instrument of a system of industrial self-government, like words in a statute, are to be understood only by reference to the background which gave rise to their inclusion.

The Court has rejected the "plain meaning" rule as a short cut for determining legislative intent. In

Boston Sand & Gravel Co. v. United States, 278 U.S. 41, 48 (1928), the Court wrote:

> It is said that when the meaning of language is plain we are not to resort to evidence in order to raise doubts. That is rather an axiom of experience than a rule of law, and does not preclude consideration of persuasive evidence if it exists.

In *United States v. Witkovich*, 353 U.S. 194, 199 (1957), the Court refused to enforce what appeared to be the literal words of a statute, stating: "[O]nce the tyranny of literalness is rejected, all relevant considerations for giving a rational content to the words become operative." In *United States v. American Trucking Ass'ns*, 310 U.S. 534, 542 550 (1934), the Court reiterated the rule that the "literal meaning" of a statute would be disregarded if necessary to enforce Congressional intent.

A contracting party's understanding of its contractual obligations, revealed in word or deed, is a significant, if not controlling, indicator of intent and the meaning of the contractual words chosen. *Old Colony Trust Co. v. City of Omaha*, 230 U.S. 100, 118 (1913) ("the practical interpretation of a contract by the parties to it for any considerable period of time before it comes to be the subject of controversy is deemed of great, if not controlling, influence"); *Brooklyn Life Ins. Co. v. Dutcher*, 95 U.S. 269, 273 (1877) ("There is no surer way to find out what parties meant, than to see what they have done.").

Here, petitioners and their allied amicus curiae propose a "tyranny of literalness" for CBAs. They say that, unless a CBA is crystal clear about the em-

ployer's obligation to provide lifetime retiree healthcare benefits, there can be no obligation. They argue that, absent *vesting* or *lifetime* "magic words" in the CBA, courts are precluded from considering: 1) context – what Justice Brennan called the "background which gave rise" to the inclusion of the contractual words; and 2) other extrinsic evidence of the employer's actual intent. The adoption of such a rigid rule is contrary to the historical function of the judiciary: to ascertain and enforce the actual intent of the contracting parties.[5]

Federal courts must be able to consider all probative evidence in determining whether an employer to

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[5] Even in the Third Circuit, which petitioners cite in their Questions Presented as requiring a "clear statement" of intent to vest retiree healthcare benefits, the court recognizes the relevance and importance of direct extrinsic evidence of intent. In *UAW v. Skinner Engine Co.*, 188 F.3d 130, 143-44 (3d Cir. 1999), the court concluded that the CBA was unambiguous, in part because the language that healthcare benefits "will continue" or "will remain" applied to retirees and active employees, and no one contended that active employees had vested healthcare benefits. The court rejected testimony from the company's former chief operating officer that, in his opinion, retirees had a right to vested healthcare benefits. The court cited the traditional rule that extrinsic evidence cannot be used to create an ambiguity where none exists (although it can be used to disclose an ambiguity). *Id.* at 145. The court stated that the former COO's testimony was not based on the language of the CBA, "but on his notion of moral responsibility." *Id.* at 146. According to the court, the former COO did not testify that, in using the phrases "will continue" or "will remain," the company intended that language to mean that retiree benefits were vested. The court observed, however: "If he had, the outcome of this case would no doubt be different." *Id.* at 147.

a CBA actually promised lifetime retiree healthcare benefits. This analysis must be free of rigid constraints that ignore context and foreclose traditional judicial evidentiary analysis. District courts in the Sixth Circuit have fulfilled their historic legal role of ascertaining the parties' contractual intent. In the four cases surveyed below, the district courts meticulously reviewed the contract language, the context in which it was negotiated, admissions and other relevant extrinsic evidence of intent. Despite the absence of words like *vested* or *lifetime* in the CBAs, this evidence proved conclusively that the employers intended their contractual promise of healthcare benefits to last for the lifetimes of retirees and their surviving spouses.

C. ERISA Provides No Guidance On Contractual Intent

The Employee Retiree Income Security Act of 1974 (ERISA), 29 U.S.C. §1001 et seq., was enacted on September 2, 1974. In ERISA, Congress required vesting and funding of pension benefits, but did not mandate vesting or funding of welfare benefits. Courts routinely reference this statutory history to preface discussion of the legal standards applicable to interpreting collectively bargained retiree healthcare provisions. *See, e.g. UAW v. Skinner Engine Co.*, 188 F.3d 130, 137-38 (3d Cir. 1999); *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 133 (2d Cir. 1999) (citing "the general rule" under ERISA "that an employee welfare plan is not vested and that an employer has the right to terminate or unilaterally to amend the plan at any time.") (*quoting Schonholz v. Long Island Jewish Medical Center*, 87 F.3d 72, 77 (2d Cir. 1996).

References to what ERISA requires, however, provide no guidance on what parties intended to require of themselves in collective bargaining.

Promises in CBAs to provide lifetime retiree healthcare benefits precede the effective date of ERISA by up to a decade. In enacting ERISA, Congress did not retroactively alter existing contractual promises enforceable under federal labor laws. Indeed, Congress expressly "prohibited" the modification or impairment of *any* existing law of the United States. 29 U.S.C. §1144(d).

Nor did Congress impose limitations on future employer agreements promising retiree healthcare benefits. ERISA left the substance and duration of welfare benefits to the discretion of "at will" employers and, in the case of unionized employers, to promises made in CBAs. *InterModal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997). And, under federal labor law pre-dating ERISA, Congress and the courts freed employers and unions from government interference or compulsion in reaching collective bargained agreements. *Carbon Fuel Co. v. Mine Workers*, 444 U.S. 212, 218-19 (1979). Once an agreement is reached, Section 301 provides the legal standards for judicial interpretation and enforcement of CBAs.

As noted, federal courts construed labor agreements promising vested retiree welfare benefits in Section 301 suits long before ERISA. *Upholsterers v. American Pad & Textile Co.*, 372 F.2d 427 (6th Cir. 1967) (life insurance vested under CBA); *Pittsburgh Plate Glass v. NLRB*, 427 F.2d 936, 947 (6th Cir. 1970) (when retiree welfare benefits have been bargained

for and earned under CBA, employer cannot recant contractual obligations). In affirming *Chemical Workers v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 181 n.20 (1971), the Court emphasized that the source of retiree rights to enforce the collectively bargained promise of lifetime healthcare benefits is Section 301:

> Under established contract principles, vested retirement rights may not be altered without the pensioner's consent. . . . The retiree, moreover, would have a federal remedy under § 301 of the Labor Management Relations Act for breach of contract if his benefits were unilaterally changed. (citation omitted).

Congress' expressed policy in ERISA is to "protect . . . the interests of participants in employer benefit plans . . . ." 29 U.S.C §1001(b). While ERISA provided another basis for enforcing collectively bargained benefit promises, obligations under CBAs are determined according to original intent of the contracting parties. As with all contracts, that intent is ascertained from the words used in those contracts, from contractual context and from evidence of how the parties themselves view and act on their obligations. In ERISA, Congress did not, and did not intend to, erect rigid barriers or "magic word" hurdles to the traditional judicial inquiry into what contracting employers intended collectively bargained benefit plans to provide.

D. Retiree Healthcare Litigation In The Sixth Circuit

This brief focuses on four cases litigated by under-

signed counsel over the past quarter century. In each case, the courts considered the retirees' evidence of the employer's actual intent without relying on presumptions or inferences.[6] The courts rejected the employer's argument for a heightened legal standard that would have foreclosed probative evidence of what the employers actually intended when they first promised in CBAs to provide retiree healthcare. *See, e.g., Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571, 580 n.5 (6th Cir. 2006); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 655 (6th Cir. 1996).[7]

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[6] Other district courts conducted similar analyses of all evidence of intent – including CBA language, contractual context, admissions and other extrinsic evidence – and concluded that the overwhelming evidence demonstrated that employers had obligated themselves to providing lifetime retiree healthcare benefits. *See e.g., Cole v. ArvinMeritor, Inc.*, 516 F. Supp. 2d 850, 858-864 (E.D. Mich. 2005)(citing extensive employer admissions by word and deed and other definitive extrinsic evidence of employer intent). The district subsequently granted the retirees' motion for summary judgment. *Cole v. ArvinMeritor, Inc.*, 515 F. Supp. 2d 791 (E.D. Mich. 2006), *aff'd*, 549 F.3d 1064 (6th Cir. 2008).

[7] Each CBA also contained a general durational clause, and, in some cases, a durational clause in the insurance agreement itself, that the employer argued was inconsistent with a promise of lifetime retiree healthcare. Nevertheless, in each case, the court concluded that the language of the CBA as a whole and the extrinsic evidence of intent showed the employer had promised lifetime benefits to retirees and surviving spouses. *See, e.g., Yolton v. El Paso Tennessee Pipeline Co.*, 318 F. Supp. 2d 455, 467 (E.D. Mich. 2003), *aff'd*, 435 F.3d 571, 580-81 (6th Cir. 2006); *Golden v. Kelsey-Hayes Co.*, 845 F. Supp. 410, 414 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996); *Fox v. Massey-Ferguson, Inc.*, 172 F.R.D. 653, 677 (E.D. Mich. 1995), *aff'd*, 91 F.3d 143 (6th Cir. 1996); *Gilbert v. Doehler-Jarvis Co.*, 87 F. Supp. 2d 788, 791 (N.D. Ohio 2000).

In discussing these cases, the Retiree Committees set forth the language of the CBAs relating to retiree healthcare, followed by a summary of evidence conclusively showing that contracting employers promised, and intended to promise, healthcare benefits for the lifetimes of retirees and surviving spouses.

1. *Golden v. Kelsey-Hayes Co.*[8]

In 1965 negotiations with the UAW, Kelsey-Hayes agreed to provide fully paid healthcare coverage for hourly retirees at its Detroit, Heintz, Speco and Gunite plants and to allow the retirees' surviving spouses to continue healthcare coverage by paying the premium. In the 1968 negotiations, Kelsey-Hayes agreed to pay the full cost of healthcare for surviving spouses. *Golden v. Kelsey-Hayes Co.*, 954 F. Supp. 1173, 1178 (E.D. Mich. 1996).

The CBA language pertaining to retiree healthcare remained basically unchanged over the years after 1968. The following are excerpts from the Insurance Supplement to the 1980 Detroit CBA:

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[8] In *Golden v. Kelsey-Hayes*, the district court issued a preliminary injunction restoring retiree healthcare benefits shortly after Kelsey-Hayes unilaterally imposed benefit cuts. *Golden v. Kelsey-Hayes Co.*, 845 F. Supp. 410 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996). After the district court granted the retirees' motion for summary judgment, *Golden v. Kelsey-Hayes Co.*, 954 F. Supp. 1173, 1178 (E.D. Mich. 1996), the parties entered into a Settlement Agreement, under which Kelsey-Hayes provides fully-paid, lifetime retiree healthcare benefits at the levels in place immediately before the January 1994 reductions.

ARTICLE I
ESTABLISHMENT, FINANCING AND ADMINISTRATION OF INSURANCE PROGRAM

. . .

Section 3. Company Contributions and Administration

. . .

(b) Company Contributions for Health Care Coverages

. . .

(7) For Retired Employes . . .

The Company shall contribute the full premium or subscription charge for Health Care (including Vision effective March 1, 1981) Coverages continued in accordance with Article III, Section 5, for:

(i) A retired employe and his eligible dependents, if any, provided such retired employe is eligible for benefits under Article II of the Kelsey-Hayes Hourly-Rate and Salaried Employes Within a Bargaining Unit Pension Plan.

. . .

(8) For Surviving Spouses

(i) The Company shall contribute the full premium or subscription charge for Health Care (including Vision effective March, 1981). Coverages continued in accordance with Article III, Section 6(b) on behalf of a surviving spouse as defined in Article III, Section 6(b), (1), (2), (3), (4) . . .

ARTICLE III
HEALTH CARE BENEFITS

. . .

Section 5. Continuation of Health Care Coverages Upon Retirement . . .

(a) The Health Care (Other Than Vision prior to March 1, 1981)

Coverages an employe has under this Article at the time of retirement . . . shall be continued thereafter provided that such continuation can be made with the carrier(s). Contributions for such coverages so continued shall be in accordance with Article I, Section 3(b)(7).

Section 6. Continuation of Health Care (other than Vision) Coverages for Surviving Spouse of an Employe or a Retired or Certain Former Employe

. . .

(b) The Company shall make suitable arrangements for a surviving spouse.

(1) of an employe or retired employe, (but not a former employe eligible for a deferred pension) if such spouse is receiving or is eligible to receive a benefit under Article II of the Kelsey-Hayes Hourly-Rate Employes and Salaried Employes Within a Bargaining Unit Pension Plan

(2) of a retired employe if, prior to his death, he was receiving a benefit under Article II of the Kelsey-Hayes Hourly-Rate Employes and Salaried Employes Within a Bargaining Unit Pension Plan,

. . .

> (4) of an employe who at the time of his death was eligible to retire on an early or normal pension under Article II of the Kelsey-Hayes Hourly-Rate Employes and Salaried Employes Within a Bargaining Unit Pension Plan, to participate in the Health (other than Vision prior to March 1, 1981). . . .

Immediately after the 1965 negotiations, Joseph Carey, a Kelsey-Hayes' bargainer, created a "list of insurance procedures" for Detroit hourly employees.[9] One such procedure was that a surviving spouse receiving a pension could continue healthcare coverage "by contributing the monthly group rate. Coverage would be continued for the lifetime of the retiree's spouse."

In 1973, Rene Slater, a Kelsey-Hayes corporate benefit representative, provided benefit personnel with summaries of "insurance continuation rights" under the 1965, 1968 and 1971 Detroit and Jackson CBAs. Each summary described retiree hospital, surgical and medical benefits for retirees as "continuation with Company contribution for life."

Beginning in early 1967, and continuing for twenty years, Kelsey-Hayes, through a dozen benefit representatives, responded to retirees' requests; wrote condolence letters to surviving spouses; and prepared benefit summaries. All assured retirees and their surviving spouses they were entitled to continued Com-

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[9] The Detroit CBA Insurance Supplement and other documents referenced in this section can be viewed at http://www.michworklaw.com/goldenvkelseyhayes/

pany paid healthcare benefits for life. In February 1967, a Detroit insurance-pension department representative told a retiree he would continue to be covered with healthcare coverage "until death."

In August 1972, the director of industrial relations in Detroit wrote to a surviving spouse that "the company will continue monthly payments for hospital, medical surgical and prescription drug benefits for your lifetime." In 1975, a Gunite personnel representative wrote an attorney that the surviving spouse of an hourly retiree would "retain medical insurance coverage for her lifetime." In 1976, a Detroit personnel representative wrote the Veteran's Administration that an hourly retiree that his medical insurance "is paid for by the Company for the rest of his life." In 1979, a Detroit employee benefits representative advised an attorney that a surviving spouse was "entitled to continued Company paid BC/BS, Dental and Hearing Aid Expense coverage for the rest of her life."

In 1981, a Speco benefits administrator wrote a note on a letter to the surviving spouse of an hourly employee eligible to retire that she was "entitled to Company-paid healthcare for her further lifetime." In 1983, an employee services supervisor wrote to a surviving spouse she was "entitled to life-time Healthcare Benefits." In 1986, a Gunite benefits representative responded to the inquiry of an hourly retiree that if he died before his spouse, she "would be covered until her death. The coverage would be the same as it is now." In November 1986, a Speco benefits representative prepared a benefit summary for the widow of an hourly retiree that medical coverage "will

be continued at no cost to you for your further lifetime."

Kelsey-Hayes prepared a form entitled "Surviving Spouse Benefit Summary" that provided "All Kelsey-Hayes healthcare coverage will continue through your life time at the expense of Kelsey-Hayes Company." A Romulus employee benefits coordinator sent a completed summary to the surviving spouse of a deceased hourly employee who signed and returned it in October 1987.

Kelsey-Hayes continued to provide healthcare benefits for hourly retirees and surviving spouses after the expiration of CBAs, including during strikes and for more than six years after it sold the Heintz, Speco and Gunite plants.

Kelsey-Hayes prepared and distributed summary plan descriptions during the late 1970s and early 1980s stating, *inter alia*, that "when you are retired, . . . all of your Healthcare coverages are continued without cost to you" and "[I]f you die after retirement . . . all Healthcare . . . benefits will be provided and Kelsey-Hayes will pay the full cost for the lifetime of your surviving spouse."

In its 1996 decision granting summary judgment for the retirees, the district court concluded that the CBA language provided for vested healthcare benefits. It supported that conclusion by reference to the "veritable mountain of evidence" demonstrating Kelsey-Hayes' intent to provide lifetime healthcare benefits to retirees and surviving spouses. *Golden v. Kelsey-Hayes Co.*, 954 F. Supp. 1173, 1176-82, 1188 (E.D. Mich. 1996).

2. *Fox v. Massey-Ferguson, Inc.*[10]

In 1964 negotiations with the UAW, Massey-Ferguson agreed to pay the full cost of retiree healthcare benefits. *Fox v. Massey-Ferguson, Inc.*, 172 F.R.D. 653, 678 (E.D. Mich. 1995). In 1967 negotiations, Massey-Ferguson agreed to pay the cost of healthcare benefits for surviving spouses of retirees. Subsequent CBAs retained basically the same language on retiree healthcare benefits.

The 1980 Insurance Agreement contained the following provisions:

> 1.07 Surviving Spouse of Deceased Employee or Pensioner. A surviving spouse:
>
> . . .
>
> (b) of a pensioner retired on or after January 1, 1965, under any pension agreement between the parties . . . whether or not the pensioner elected a survivor option:
>
> . . .
>
> shall effective August 1, 1968, have the option

[10] Massey-Ferguson, like Kelsey-Hayes, implemented cuts to retiree healthcare benefits effective January 1, 1994. After considerable discovery and litigation over venue, the district court granted the retirees' motion for a preliminary injunction in May 1995. *Fox v. Massey-Ferguson, Inc.*, 172 F.R.D. 653, 678 (E.D. Mich. 1995), *aff'd*, 91 F.3d 143 (6th Cir. 1996). In September 1996, the district court conducted a bench trial during which additional evidence was introduced. Massey-Ferguson thereafter agreed to provide fully-paid, lifetime benefits for retirees and surviving spouses under a 1998 Settlement Agreement.

of continuing company paid health benefit coverage . . . by electing such coverage for herself and any eligible dependents not later than three (3) months after the death of the . . . pensioner. . . . Commencing with the month in which the spouse becomes eligible for Medicare . . . , the company will continue premium contributions only for months in which the spouse has the voluntary coverage that is available under [Medicare].

. . .

5.05 Health Benefits.

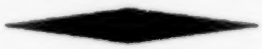
(a) Effective March 1, 1980, pensioners, surviving spouses and their dependents . . . shall be eligible for the dental expense benefits coverage set forth in Article III, the vision expense benefits coverage set forth in Article IV, the hearing aid benefits as set forth in the agreement on Hearing Aid Program and Benefits and the health benefits coverage set forth in 2.07, 2.08, and 2.10.

Effective with the first day of the month following the month in which a pensioner or dependent who is eligible for health benefits under 5.05 becomes eligible for hospital, surgical and medical benefits, under the Federal Social Security Act, such benefits shall be coordinated with the health benefits plan provided by the company with the company considered secondary carrier. . . .

7.01 The following terms shall have the meanings set forth below unless the context clearly indicates otherwise:

. . .

> (i) Pensioner. A former bargaining unit employee . . . who has retired from employment with the company and who is receiving or is entitled to receive a current pension.



Massey-Ferguson's corporate benefit manager, who participated in the 1965 and 1968 negotiations, testified that "it was always the understanding [of Massey-Ferguson] that these benefits were not only negotiated but in the mind of the Company provided for the pensioner's life . . . it wasn't just something that was dragged out of [the company] and we made a point of telling our pensioners so."

Documents created by Massey-Ferguson thereafter bear this out.[11] In December 1969, a corporate benefit representative wrote a memo to Detroit plant labor relations representative about the surviving spouse of an hourly employee: "Mrs. Lindow will receive helth [sic] insurance coverage for remainder of her lifetime company paid."

Beginning with a May 1979 condolence letter, at least six Massey-Ferguson corporate benefit representatives assured surviving spouses of recently-deceased hourly retirees over a ten-year period that, for example: "As the survivor of an MF pensioner, you will continue to be eligible for company paid health and dental benefits for the rest of

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[11] The Insurance Agreement and other referenced documents can be viewed at http://www.michworklaw.com/foxvmasseyferguson/

your life" or that "Massey-Ferguson will continue your health, dental, vision and hearing aid benefit coverage for the rest of your life at no cost to you." More than 70 of these letters were discovered in corporate benefit files during litigation.

Corporate benefit representatives consistently responded to individual inquiries from employees, pensioners and surviving spouses with the same assurances: "Your wife will have medical benefits for the rest of her life . . . ;" "Should you die before your wife, she will receive Company-paid health coverage for the rest of her life;" "You and your wife both have medical benefits from Massey-Ferguson for the rest of your lives;" "If you pass away, your spouse will receive a pension . . . . She will also have medical coverage for her lifetime." In February 1991, a corporate benefits representative responded to an inquiry from the Iowa Department of Human Resources that a retiree "has family coverage for medical, dental, vision and drugs. Non-contributory premium. Coverage for lifetime of retiree and spouse."

Massey-Ferguson continued to provide benefits to retirees and surviving spouses for nearly ten years after it closed its Detroit manufacturing plant in 1985 and the Master CBA had terminated.

Based on the CBA language and extrinsic evidence such as this, the district court granted the retirees' motion for a preliminary injunction in May 1995. *Fox v. Massey-Ferguson, Inc.*, 172 F.R.D. 653, 676-78 (E.D. Mich. 1995), *aff'd*, 91 F.3d 143 (6th Cir. 1996).

3. *Gilbert v. Doehler-Jarvis, Inc.*[12]

Retiree healthcare benefits were first negotiated for Doehler-Jarvis hourly retirees in 1965. In 1980, Doehler-Jarvis agreed to provide surviving spouses with fully-paid retiree healthcare benefits "until such time as the surviving spouse shall remarry." The CBA pertaining to retiree healthcare benefits remained substantially unchanged through the 1996 CBA.

The 1996 Doehler-Jarvis Insurance Program, a CBA supplement, provided at Article III:

Section 3. Company Contributions

. . .

(c) For Retired Employees

The Company will make monthly contributions for the following month's coverage on behalf of

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[12] NL sued the UAW in New York for a declaratory judgment that it had no contractual obligation to provide retiree healthcare benefits. *NL Industries, Inc. v. UAW*, C.A. 87-1292 (W.D.N.Y.). Farley sued the UAW and an individual retiree in Pennsylvania in 1990 for a similar declaratory judgment. *Farley, Inc. v. UAW*, C.A. 90-6915 (E.D. Pa.). In each case, a class of retirees filed a coercive action to enforce their rights to lifetime healthcare benefits. In 1992, the parties reached separate settlement agreements under which NL and Farley agreed to provide comprehensive, healthcare benefits for the lives of retirees and for life or until the remarriage of surviving spouses.

In 1990, Farley sold the assets of Doehler-Jarvis to Harvard Industries. In 1999, Harvard announced that it intended to terminate retiree healthcare benefits at the end of the then current CBA and filed a declaratory judgment action in Pennsylvania. Post-Farley retirees filed an action in the Northern District of Ohio where the case was ultimately litigated.

(1) Retired Employees (not including a former Employee entitled to or receiving a deferred vested pension) and,

(2) Employees terminating after age 65 (except those whose discharge for cause has not been appealed, or if appealed, has been finally upheld) with insufficient credited service to entitle them to a retirement benefit under the Retirement Plan and their eligible dependents, towards the cost of Hospital-Surgical-Medical and Prescription Drug Coverages equal to the full monthly charge.

The continued coverage to which retired Employees are entitled will be only the applicable coverages as described in Section 1 above. The Company may, from time to time, request that retired Employees attest to the eligibility status of their dependents towards whose coverage the Company contributes. If the retired Employee fails to comply with such request, the Company may reduce the retired Employee's coverage to that of "self-only," unless it can be demonstrated that he has an eligible dependent.

(d) For Surviving Spouse

The Company will make monthly contributions for Hospital-Surgical-Medical and Prescription Drug Coverages on behalf of the surviving spouse (and the spouse's eligible dependents).

(1) Of an Employee, as long as monthly Survivor Income Benefits provided in Article II, Section 5 are payable.

(2) Of an Employee who at the time of his death was eligible to retire on an Early or Normal Pension under Article II of the Doehler-Jarvis, Inc. Pension Plan for Wage Basis Employees.

(3) Of a retired Employee if, prior to his death, he was receiving a benefit under Article II of the Doehler-Jarvis, Inc. Pension Plan for Wage Basis Employees.

Contributions shall be continued until such time as the surviving spouse shall remarry.

The Company may from time to time request that surviving spouses attest to the eligibility status of themselves and their dependents towards whose coverage the Company contributes. If the surviving spouse fails to comply with such request, the Company may cease contributions toward the surviving spouse's coverage.

Robert Bressler, the chief negotiator for Doehler-Jarvis in the 1965 negotiations, stated in his 1990 Affidavit: "It was the intention of the Company that the retiree medical insurance would last for the life of the retiree. . . . When an employee fulfilled the requirements for retiree medical insurance, he or she was entitled to those benefits for life regardless of what happened to the underlying collective bargaining agreement." [13]

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[13] The Insurance Program, affidavits and other documents referenced in this section can be viewed at http://www.michworklaw.com/gilbertvdoehlerjarvis/

Edward Roman participated in the 1965 negotiations as the industrial relations manager for Toledo Plants 1 and 2. Mr. Roman stated in his 1990 Affidavit: "During the 1965 negotiations with the UAW, Doehler-Jarvis agreed to provide company-paid medical insurance benefits for hourly rated employees. This benefit was intended by Doehler-Jarvis to last for the life of the retiree." He and Mr. Bressler represented Doehler-Jarvis on the Union Management Committee that finalized the language for the 1965 CBA. He stated: "It was my intention that the language that was drafted by the Union Management Committee for retiree medical insurance reflect the fact that those benefits were to last as long as the individual was retired or, in other words, for life."

Donald Burkel was the assistant employment manager at the Batavia, New York plant from 1966 through 1970 and insurance administrator through 1973. Mr. Bressler came to the Batavia facility and told Mr. Burkel that the person conducting exit interviews for hourly retirees should inform them they would have medical insurance benefits for the rest of their lives. Mr. Burkel did so.

Doehler-Jarvis agreed in the 1980 negotiations to extend company paid medical insurance coverage to surviving spouses of retirees "until the surviving spouse shall remarry." According to Jack Johnson, Doehler-Jarvis' manager of compensation and benefits, who participated in the 1977 and 1980 negotiations with the UAW:

> These benefits were negotiated on the same basis as my understanding about retiree medical insurance benefits, that is, that they were lifetime

benefits. With respect to surviving spouses, however, Doehler-Jarvis and the UAW agreed that the benefits would be terminated if the surviving spouse remarried. Otherwise, it was a lifetime benefit.

Six division and plant benefits personnel at three Doehler-Jarvis facilities provided affidavits stating that they informed retiring hourly employees they were entitled to lifetime healthcare benefits. Doehler-Jarvis division and plant benefits personnel consistently made the same assurances in writing. From at least 1976 through 1989, a dozen division and corporate benefit representatives wrote dozens of letters to retiring employees, retirees and surviving spouses. Retiring employees were informed: "Your healthcare coverage will be continued for you and your dependents at no cost to you for your lifetime." Hourly retirees were told: "your Blue Cross-Blue Shield insurance will be covered for the rest of your life." Surviving spouses were assured that they were entitled to continued health coverage "for your lifetime or until you remarry."

Before NL's sale of Doehler-Jarvis to Farley in 1982, NL's director of industrial relations Richard Henzel met with the purchaser William Farley and they discussed the duration of collectively bargained retiree healthcare benefits. Mr. Henzel testified at his 1990 deposition: "And I told Bill that those were lifetime benefits that had been agreed upon. It didn't come as any revelation to him."

After it sold Doehler-Jarvis to Farley in 1982, NL continued to provide retiree health care benefits to retirees and surviving spouses from its

closed Grand Rapids and Batavia plants. Corporate benefits representatives continued to send condolence letters to surviving spouses of Doehler-Jarvis hourly retirees, assuring them they would have: "Continued medical coverage for the rest of your life or until you remarry." At least seven corporate benefit representatives sent these letters. Two NL officers admittedly knew these letters were being mailed to surviving spouses. NL benefit representatives gave the same assurances in response to direct inquiries from retirees: "Should you pre-decease your wife, her medical coverage will continue for the rest of her life or remarriage." NL sent these letters assuring surviving spouses they were entitled to healthcare benefits for life or until remarriage through 1987.

After its 1982 purchase of Doehler-Jarvis, and through 1989, Farley benefit representatives consistently assured surviving spouses that they would "continue to be covered under the group healthcare plan for the rest of your life or until you would remarry."

In 2000, the district court granted summary judgment to post-1990 retirees. *Gilbert v. Doehler-Jarvis, Inc.*, 87 F. Supp. 2d 788 (N.D. Ohio 2000). After analyzing the language of the CBA, the court summarized the "unrebutted evidence" of employer intent, including the affidavits of "individuals who negotiated the original CBA" and the correspondence from company benefit representatives to retirees and surviving spouses assuring them that they were entitled to lifetime healthcare benefits. *Id.* at 792.

4. *Yolton v. El Paso Tennessee Pipeline Co.*[14]

Case Corporation (then known as JI Case) agreed to provide fully paid retiree healthcare benefits for retirees over age 65 in the 1971 negotiations with the UAW. In the 1974 negotiations, Case agreed to extend fully-paid healthcare benefits for retirees and surviving spouses under age 65, effective January 1, 1975.

Article III of the 1974 JI Case Group Insurance Plan, a supplement to the 1974 CBA, has the following provisions pertaining to retiree healthcare benefits:

J. Provisions Applicable to Employees Retired on Company Pension and Surviving Spouses Receiving Company Pension:

1) Employees who retire under the JI Case Pension Plan for Hourly Paid Employees, or their surviving spouses eligible to receive a spouse's pension under the provisions of that Plan, shall be eligible for the Group Insurance benefits as described in the following paragraphs.

. . .

(i) Major Medical Expense Insurance

(ii) Prescription Drug Plan

. . .

---

[14] Beginning September 2002, El Paso, the plan sponsor for pre-reorganization Case Corporation retirees, required hourly retirees and surviving spouses to pay premiums to continue their healthcare coverage. The retirees sued and obtained a preliminary injunction restoring their benefits. *Yolton v. El Paso Tennessee Pipeline Co.*, 318 F. Supp. 2d 455 (E.D. Mich. 2003), *aff'd*, 435 F.3d 571 (6th Cir. 2006).

3) Contribution for Coverage

. . .

b) Major Medical Expense Insurance and the Prescription Drug Plan

(i) For eligible Retired Employees and Surviving Spouses who have enrolled and are age 65 or older, the Company shall pay the full premium cost of the above coverages.

(ii) Effective January 1, 1975, for eligible Retired Employees and Surviving Spouses who have enrolled and are under age 65, the Company shall pay the full premium cost of the above coverages.

Clement Devine participated in the 1971 negotiations when the current retiree healthcare language was first negotiated, as Case's director of benefits and one of three management representatives on the company's benefit subcommittee. After the negotiations, Mr. Devine wrote a December 30, 1971 letter to hourly retirees and surviving spouses.[15] He explained what Case had agreed to do for them in collective bargaining. He wrote the letter in a question and answer format because that would "be the most understandable and anticipating the questions most of you have in

[15] The Group Insurance Plan and documents described in this section can be viewed at http://www.michworklaw.com/yoltonvelpaso/

mind." Question 3 was "Will a Premium be Required?" The "answer" was: "Retirees and Surviving Spouses, age 65 or older, are not required to pay a premium, either for themselves or any dependent. Instead, the coverage shall be fully paid by the Company." In answer to Question 9, "Will my spouse be able to keep this coverage if I pass away?" Mr. Devine assured the retirees: "If you have elected the Spouse's Optional Form of Pension and your spouse will receive a pension as a result, your spouse will be able to keep this coverage for the remainder of her lifetime."

Nearly 20 years later, after participating in the 1990 negotiations, Mr. Devine wrote to the surviving spouse of a disabled employee. He told her that, during the 1990 negotiations, the company had agreed to extend the same healthcare coverage to her as "those provided to other surviving spouses of deceased retirees . . . ." He added: "You will have these coverages for your lifetime."

Other corporate and plant benefit representatives told hourly retirees and surviving spouses the same thing. In 1980, a benefits specialist at the Burlington plant wrote to an attorney for the widow of an hourly retiree: "Mrs. Rambo will be entitled to full medical and dental coverage. This coverage will continue in effect for her lifetime or, in the event of her remarriage, until the date of her remarriage." She wrote other letters and benefit summaries for retirees and surviving spouses through 1997.

In the early 1980s, JI Case provided retiring hourly employees with a written summary of the benefits they would have in retirement: "Your [sic] are entitled to full coverage for Medical, dental, vision, prescrip-

tion drugs, and hearing aids the same as when you were employed as long as you have ten years of service at the time of your retirement. Your spouse is also covered just the same as you. If you have completed the portion of the retirement application electing the spouse's option (no charge if spouse is within ten years of your age) then if you should die before that person, their coverage would continue as before. Their coverage would terminate if they remarry. . . ." Later in the summary, Case stated: "In the event you should die before your spouse and a spouse's option was spplied [sic] for, she will receive 55% of your pension for her lifetime along with the insurance which was mentioned previously. . . ."

Robert Lacke, a signatory to the 1974, 1977 and 1980 CBAs for JI Case from its Bettendorf plant, wrote a notation relating to benefits due an hourly employee, in which he compared long term disability (LTD) benefits with benefits under a disability pension. In the LTD column, Mr. Lacke wrote "no automatic spouse option without thirty years of service therefore no Med. Ins." In the disability pension column, Mr. Lacke wrote: "spouse option $135.33 + Med. Ins. Balance of Spouses life."

In 1986, a corporate benefits representative wrote to the surviving spouse of an East Moline retiree stating that "Group Insurance coverage will be continued for you at no cost for your lifetime. Coverage will, however, cease if you remarry." In 1989, the benefits coordinator at the Racine plant wrote to the surviving spouse of an hourly employee who died before retirement: "As Richard was eligible to retire, you are entitled to an automatic spouse's pension for life. You are

also entitled to free group coverage (unless you remarry)."

At Terre Haute, when an hourly employee retired, the supervisor of benefits explained the pension and insurance benefits the retiring employee would receive. Often, the employee's spouse and a union representative would also be present. She informed retiring employees that Case would provide them fully paid healthcare benefits for life. She told retiring employees that, if they were married and chose the survivor pension benefit, their spouses would have lifetime healthcare benefits if they died first. She prepared worksheets showing the benefits available for surviving spouses in the event of the retiree's death, including life insurance benefits, transition and bridge benefits and the duration of those benefits (bridge benefits were payable to age 62 or remarriage) and the amount of the survivor pension benefit. As to the healthcare benefits, she, sometimes wrote and sometimes typed: "Medical: For lifetime."

When a Terre Haute hourly retiree died in November 1984, his surviving spouse received a summary informing her she was entitled to an automatic spouse's pension benefit and "[t]he major medical, dental, vision, hearing and prescription drug coverage will also continue unchanged for your lifetime, or date of remarriage."

When the Terre Haute plant closed in 1987, the benefits supervisor wrote to employees who had selected a "grow in" option under the plant closing agreement. She included healthcare cards that expired on the date the special early retirement began. She wrote: "You will then receive a permanent

(plastic) card from Metropolitan which will reflect your lifetime coverage." Thereafter, hourly retirees were issued MediMet cards containing the language "Lifetime Coverage" or "Lifetime." The company continued to provide healthcare to retirees and surviving spouses from Terre Haute and other plants for fifteen years after they were closed and the CBA terminated.

At the East Moline plant, Case benefit representatives conducted seminars for hourly employees considering retirement under a special early retirement program available in 1991 and 1992. Benefit summary sheets were prepared for and distributed at the meetings describing pension benefits available to employees who elected to retire under the program. The summary stated: "the surviving spouse will continue coverage for all medical, dental, vision, etc. benefits for life."

In 1993, Case announced the closings of Wausau, Southhaven Depot and part of the Hinsdale plant. Case and the UAW entered into a plant shutdown agreement. Case's corporate Human Resources Department prepared a summary for the plant closing entitled "Closed Plant Benefits." Hourly employees who selected special early retirement benefits would: "Receive retiree medical benefits for life."

In December 2003, the district court granted the retirees' motion for a preliminary injunction. *Yolton v. El Paso Tennessee Pipeline Co.*, 318 F. Supp. 2d 455 (E.D. Mich. 2003), *aff'd*, 435 F.3d 571 (6th Cir. 2006). In 2008, after extensive discovery unearthed further evidence of the company's intent, the district court granted Plaintiffs' motion for summary judgment.

Yolton v. El Paso Tennessee Pipeline Co., 2008 U.S. Dist. LEXIS 17619 (E.D. Mich. 2008).

IV. CONCLUSION

In these four cases, evidence of the employer's intent came from the language of the CBAs, but not from "clear statements" using terms like lifetime or vested. Rather, the definitive evidence that employers had promised to provide lifetime retiree healthcare benefits came from: 1) the context provided by other CBA terms; 2) employer representatives who testified that they intended the CBA language to convey their promise of lifetime retiree healthcare benefits; 3) contemporaneous internal communications of employer negotiators describing the new contractual promise as one lasting a "lifetime;" 4) the employer's words and deeds – in providing retiree healthcare benefits during strikes and after plant closings; and 5) "lifetime" communications written over decades by employer representatives entrusted with the responsibility of explaining retirement benefits to employees, retirees and surviving spouses.

In each of the four cases, the CBA expressed the parties' intent in language without the words *lifetime or vested* or any other "magic words" that would satisfy the rigid "clear statement" standard desired by petitioners and their amicus curiae. Yet, in each case, the evidence of the employer's intent and its promise to provide "lifetime" healthcare benefits was overwhelming and irrefutable. If a "clear statement" standard – or any similar limitation on the courts' ability to fully consider probative evidence – had been imposed in these cases, the result likely would have been contrary to the contracting parties' unequivocal "life-

time" intent. The employers would have evaded their promises. The retirees would have been deprived of the "benefit of their bargain" *after* having earned the right to "lifetime" healthcare benefits by decades of industrial labor.

In each of the four cases, the traditional contract interpretation rules allowed the courts to ascertain and enforce the actual intent of the contracting parties. In each case, the parties' original intent was ascertained and enforced.

Petitioners' requested *post hoc* limitations on the traditional rules of contract interpretation would facilitate the work of the courts. Rigid rules are easier to enforce. But, one-sided restrictions on interpretation of CBAs are inconsistent with the traditional judicial function: to ascertain and enforce the actual intent of the contracting parties. Barriers to the determination of one party's contractual intent would elevate form over substance at the expense of retirees who earned the right to healthcare benefits through decades of work. The Retiree Committees ask the Court to confirm that the traditional rules of contract interpretation apply to CBAs promising retiree healthcare in the same manner they do to all other contracts.

Respectfully Submitted,

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AMICUS CURIAE BRIEF

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IN THE

Supreme Court of the United States

M&G POLYMERS USA, LLC, et al.,

Petitioners,

v.

HOBERT FREEL TACKETT et al.,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF OF GOLDSTEIN & RUSSELL, P.C., AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF THE *AMICUS* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. Methodology 4

II. The Provisions 6

III. Summary Plan Descriptions 14

FURTHER INFORMATION 18

CONCLUSION 19

TABLE OF AUTHORITIES

Cases

Anderson v. Alpha Portland Indus., Inc.
836 F.2d 1512 (8th Cir. 1988)..... 13

Bland v. Fiatallis N. Am., Inc.,
401 F.3d 779 (7th Cir. 2005)..... 7

Chiles v. Ceridian Corp.
95 F.3d 1505 (10th Cir. 1996),
abrogated on other grounds CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011) 10

Golden v. Kelsey-Hayes Co.,
73 F.3d 648 (6th Cir. 1996)..... 8, 14

In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.,
58 F.3d 896 (3d Cir. 1995) 10

Joyce v. Curtiss-Wright Corp.,
171 F.3d 130 (2d Cir. 1999) 8

Linville v. Teamsters Misc. & Indus. Workers Union, Local 284,
206 F.3d 648 (6th Cir. 2000)..... 4, 11

McCoy v. Meridian Automotive Sys., Inc.,
390 F.3d 417 (6th Cir. 2004)..... 8

Murphy v. Keystone Steel & Wire Co.,
61 F.3d 560 (7th Cir. 1995)..... 10

Noe v. PolyOne Corp.,
520 F.3d 548 (6th Cir. 2008)..... 7

Policy v. Powell Pressed Steel Co.,
770 F.2d 609 (6th Cir. 1985)..... 7

Senn v. United Dominion Indus., Inc.,
951 F.2d 806 (7th Cir. 1992)..... 10, 13

Smith v. ABS Indus., Inc.,
890 F.2d 841 (6th Cir. 1989) 13

Spacek v. Maritime Ass'n,
134 F.3d 283 (5th Cir. 1998),
abrogated on other grounds Cent. Laborers' Pension Fund v. Heinz, 541 U.S. 739 (2004) 9

Tackett v. M & G Polymers USA, LLC,
733 F.3d 589 (6th Cir. 2013) 8

Turner v. Local Union No. 302, Int'l Bhd. of Teamsters,
604 F.2d 1219 (9th Cir. 1979) 10

UAW v. Rockford Powertrain, Inc.
350 F.3d 698 (7th Cir. 2003) 9

UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) 7, 13

Other Authorities

Collective Bargaining Agreements File: Online Listings of Private and public Sector Agreements, U.S. Dep't of Labor, http://www.dol.gov/olms/regs/compliance/cba/index.htm 5

INTEREST OF THE *AMICUS*[1]

This is the rare true "*amicus*" brief. It is respectfully submitted as a friend of the Court, with no agenda or desire to direct the outcome of the case. The only purpose of the brief is to provide the Court with factual information that may be useful in guiding its decision.

Amicus is a law firm that practices before the Court. The firm has no interest in the outcome of the case. Nor is it aware that any of its clients has an interest in the outcome of the case.

The genesis of the brief is a desire for members of the bar to provide the Court with assistance in deciding cases correctly. In particular, while many cases before the Court on the merits involve broad and general questions of law, or generate large numbers of thorough *amicus* submissions, others do not. A material number of cases instead involve important questions that arise in technical fields, yet generate few *amicus* briefs that elaborate on the legal issue and the factual context in which that issue regularly arises. In those cases, the bar has the ability to use its resources to provide the Court with that information.

This appears to be such a case. The Question Presented asks the Court to determine when retiree health benefits vest under collective bargaining

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[1] Pursuant to Rule 37.6, *amicus* certifies that no party's counsel authored this brief in whole or in part and that no person or entity other than *amicus* or its counsel has made a monetary contribution to the preparation or submission of this brief. Both parties have filed blanket letters of consent with the Court.

agreements (CBAs). The certiorari papers make clear that the issue arises regularly, as well as that CBAs contain diverse language implicating that question. But in their merits briefing both parties are understandably likely to focus on the particular agreement in this case. As a result, there is a realistic prospect that the Court could be left to decide the case without a thorough understanding of how the legal rule it adopts will affect the interpretation of other CBAs.

Amicus therefore undertook a simple study. It drew a sample of CBAs that contain language relating to retiree health-care benefits. It then identified what proportion of the agreements contains the various provisions to which the courts of appeals have looked in determining whether those benefits vest. Because the lower courts also frequently look to the text of the CBAs' summary plan descriptions (SPDs), *amicus* also undertook the same study of a sample of SPDs that discuss the duration of retiree health-care benefits.

Our hope is that the Court will find the information useful in developing a legal rule and understanding the implications of its decision.

SUMMARY OF ARGUMENT

Amicus reviewed a sample of 100 CBAs for language relating to the vesting of retiree health benefits. That review revealed the following:

60% of the sampled CBAs (70% private; 50% public) include at least one clause that is generally recognized to preclude vesting; some contain more than one. A small number—5% of the sample,

comprising 6% of the private agreements and 4% of the public ones—state outright that benefits do not "vest." A similar number—7% (10% private; 4% public)—give employers a unilateral right to amend eligibility standards. A greater number—23% (34% private; 12% public)—provide that benefits are guaranteed only "during the term of" the bargaining agreement. The most common language—present in 35% of all sampled CBAs (32% private; 38% public)—ties retirees' eligibility to their age or Medicare status, curtailing benefits after a period of time.

By contrast, 26% of the sampled CBAs (30% private; 22% public) contain at least one clause suggesting that benefits do vest. One public-sector CBA specifically describes retiree health benefits as "vesting." A small number of the sampled CBAs—6% (8% private; 4% public)—describe retiree health benefits as "lifetime" or "for life." Another 22% (26% private; 18% public) tie a retiree's eligibility for health-care benefits to his eligibility for pension benefits.

14% of the sampled CBAs (6% private; 22% public) include the ambiguous phrase that benefits "will continue," but do not specify a period of duration or conditions associated with that continuance.

Finally, 16% of the sampled CBAs (14% private; 18% public) were completely silent on the question of vesting.

Amicus also reviewed a smaller sample (39) of Summary Plan Descriptions (SPDs), which courts sometimes consult to determine whether benefits have vested. That analysis reveals that when SPDs speak to the question, they often prohibit vesting. However,

many SPDs are silent on the issue. Moreover, because the SPD sample was relatively small, inferences from that sample should be made lightly.

The data, and a summary of it, are available in Microsoft Excel format on *amicus*'s website at http://goo.gl/17MhsG.

ARGUMENT

The Question Presented by this case calls on the Court to decide when collective bargaining agreements (CBAs) provide for retiree health-care benefits that are "vested"—*i.e.*, benefits that "continue so long as the beneficiary remains a retiree." *Linville v. Teamsters Misc. & Indus. Workers Union, Local 284*, 206 F.3d 648, 651 (6th Cir. 2000). Recognizing that the specific CBA at issue in this case may be a poor proxy for all such agreements, this brief reviews a larger sample of agreements from both the public and private sectors.

Courts interpreting a CBA often compare the language of different provisions in the agreement, and in the case of ambiguity consider extrinsic evidence as well. This study is more limited. *Amicus* reviewed the language of CBAs provisions that has given rise to recurring issues in the lower courts. The goal is to assist the Court in understanding how the legal rule it adopts will affect later cases.

I. Methodology

The Office of Labor-Management Standards (OLMS) of the United States Department of Labor maintains an online database of CBAs. The agreements are sorted into private-sector and public-sector agreements. Each has a unique file number.

See Collective Bargaining Agreements File: Online Listings of Private and public Sector Agreements, U.S. Dep't of Labor, http://www.dol.gov/olms/regs/compliance/cba/index.htm (last modified Sept. 21, 2010). This brief cites CBAs using the following format: (*Employer Name and Union Name*, Expiration Date, OLMS File Number, URL).

Amicus studied a sample of 50 relevant CBAs from the private sector and 50 from the public sector. Moving alphabetically through the OLMS listings, *amicus* identified the first 50 agreements from each category that expressly provide retiree health-care benefits. Agreements that merely recognize employers' obligations under the Consolidated Omnibus Budget Reconciliation Act were excluded. Agreements that offer coverage to "qualified beneficiaries" but do not define the members of that class were also excluded. Only one agreement per employer was included in the sample, to ensure that the study was not biased by multiple products of a single series of negotiations.

Utilizing these criteria, *amicus* located 50 agreements in each category after reviewing 286 private-sector CBAs and 137 public-sector CBAs. According to data maintained by OLMS, the 100 sampled agreements govern the employment of more than 375,000 employees in more than 25 states—including a wide variety of professions ranging from carpentry to health care in the private sector and from transportation to university education in the public sector.

II. The Provisions

Amicus reviewed the sampled agreements for language that speaks expressly or implicitly to whether retiree health benefits vest, and recorded instances of potentially relevant language. This brief identifies how frequently particular language appeared in the sampled CBAs.

A. Express Statements of Intent

Very rarely, CBAs expressly state that retiree health-care benefits are vested. *Amicus* found only one such agreement: a public-sector agreement between containing a section entitled "Health Benefits Vesting." (*State of California and California Correctional Peace Officers Association*, 7/2/06, 800368, http://goo.gl/J3uQ1M). The sample did not include any private-sector agreements with such an explicit provision.

A small number of CBAs expressly state the opposite: that health care benefits do not "vest." 5% of all agreements (6% private; 4% public) contain such clauses. An example of such a provision is:

> It is specifically recognized that post-retirement health care benefits as well as other post-retirement benefits, excluding pension, provided hereunder are not vested and may be amended or terminated by the Company at any time (*First Energy Corp. and Utility Workers Union of America*, 6/30/11, 6007, http://goo.gl/n68rqx).

B. Language Suggesting Vesting

1. *Lifetime Benefits*: 6% of the sampled agreements (8% private; 4% public) include language stating that retirees will receive health benefits "for life."

The following clause from an agreement between Anchor Glass Container Company and the American Flint Glass Workers Union is representative:

> The present health care program for those who either became or become (and remain) eligible retirees and their eligible spouses on and after April 1, 1983, and through August 31, 2002, will be continued for their respective lives, subject to its term and conditions (8/31/05, 8756, http://goo.gl/a8lXYY).

The Third and Sixth Circuits have held that such language demonstrates a clear intent to vest. *Noe v. PolyOne Corp.*, 520 F.3d 548, 560 (6th Cir. 2008); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 141 (3d Cir. 1999); *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609, 614 (6th Cir. 1985). The Seventh Circuit has held that such language is not conclusive, but does overcome a presumption against vesting. *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779, 784-85 (7th Cir. 2005).

2. *Pension-tying*: 22% of the sampled agreements (26% private; 18% public) tie retirees' eligibility for health benefits to their pension status—*i.e.*, they provide health-care benefits only to pension beneficiaries.

A common phrasing of this clause is as follows: "[the] City will pay this premium for regular retirees and the spouses for only as long as they receive a

pension from the City" (*City of Detroit and AFSCME*, 6/30/01, 810132, http://goo.gl/p6bAOQ).

The Sixth Circuit treats pension-tying provisions as evidence of intent to vest, if retirees receive pension benefits for life. *Tackett v. M & G Polymers USA, LLC*, 733 F.3d 589, 600 (6th Cir. 2013); *McCoy v. Meridian Automotive Sys., Inc.*, 390 F.3d 417, 422 (6th Cir. 2004); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 656 (6th Cir. 1996). The Second Circuit disagrees, however. *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 134 (2d Cir. 1999).

C. Language Precluding Vesting

1. *Right to Amend*: 7% of the sampled CBAs (10% private; 4% public) provide that a party—either the company or an appointed Board of Trustees—has a full or significant ability to amend, alter, or terminate retiree health-care benefits.

The phrasing of these clauses varies, but two examples are representative:

> The Company expects to continue the Sprint Retiree Medical Plan indefinitely. However, the Company reserves the right to amend or terminate any one of the various components of the Sprint Retiree Medical Plan at any time including changing the level of Company contributions, deductibles, out of pocket maximums, and requiring retiree contributions, so long as the changes are uniformly applied to all eligible retirees (*Carolina Telephone and Telegraph Co. and*

> *Communications Workers of America*, 11/15/08, 5801, http://goo.gl/XbF19B).

And:

> The Board of Trustees of the Joint Benefit Trust shall have full authority and discretion to modify the benefits provided under options d. (3) and (4) and the premium paid by the retired employee to participate in either of those options and to eliminate either one, but not both, of those options if in their judgment it is no longer in the best interests of the Trust to continue such option (*California Processors, Inc. and Teamsters California State Council*, 6/30/12, 253, http://goo.gl/ROnF6p).[2]

Every circuit to consider the question has held that such a provision demonstrates intent to preclude vesting. *UAW v. Rockford Powertrain, Inc.* 350 F.3d 698, 704 (7th Cir. 2003); *Spacek v. Maritime Ass'n*, 134 F.3d 283, 293 (5th Cir. 1998), *abrogated on other grounds Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); *Chiles v. Ceridian Corp.* 95 F.3d 1505, 1514 (10th Cir. 1996), *abrogated on other grounds*

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[2] We do not include agreements that significantly limit the reservation of rights. For example, an agreement between the Hartford, Conn., Board of Education and the American Federation of Teachers states, "[the] Board reserves the right to change health insurance provided . . . [the] plan suggested as an alternative [contains] substantially equal coverage, benefits, portability and administration as the present plan(s) at no additional cost to the employee" (6/30/05, 830762, http://goo.gl/dTZmmm).

CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011); *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 58 F.3d 896, 904 (3d Cir. 1995).

2. *Term Limits*: 23% of the sampled CBAs (34% private; 12% public) state that benefits are guaranteed only during the term of the bargaining agreement.

The following language from an agreement between Aerospace Corporation and the Aerospace Professional Staff Association is representative:

> The monetary benefits specified within Article VIII, including specific referenced plans with regard to Group Insurance, Retirement and Voluntary Annuity, shall be continued during the term of this Agreement for bargaining unit employees (8/1/08, 4193, http://goo.gl/lmn1ok).

The courts of appeals that have considered the question agree that such a provision precludes vesting. *Murphy v. Keystone Steel & Wire Co.*, 61 F.3d 560, 566 (7th Cir. 1995); *Senn v. United Dominion Indus., Inc.*, 951 F.2d 806, 815 (7th Cir. 1992); *Turner v. Local Union No. 302, Int'l Bhd. of Teamsters*, 604 F.2d 1219, 1225 (9th Cir. 1979).

3. *Termination upon Medicare Eligibility (Or Some Other Period)*: 35% of the sampled CBAs (32% private; 38% public) provide for health-care benefits until a retiree is eligible for Medicare; some of these provisions are explicit, while others limit benefits to the age at which an individual becomes Medicare eligible—*i.e.*, age 65.

Some examples of this type of clause are the following:

> Employees who retire from Mercy Hospital of Buffalo will be eligible to participate in the group health plan, at their own expense, until they are eligible for medical coverage under Medicare (*Mercy Hospital of Buffalo and Communications Workers of America*, 6/3/08, 8050, http://goo.gl/TBVPcz).

And:

> The District shall pay the dollar amount required to provide the equivalent coverage given to active members for health insurance (medical and prescriptions) for employees who retire between the ages of fifty-five (55) and sixty-five (65) years. . . . The District's obligation for payment of such coverage shall cease upon the last day of the month preceding the month in which the retiree reaches age sixty-five (65) (*Bakersfield City School District and Bakersfield Elementary Teachers Association*, 6/30/06, 830629, http://goo.gl/i0E4EH).

The Sixth Circuit, which is the court of appeals that is most likely to deem benefits to be vested, has concluded that such a provision precludes vesting. *Linville*, 206 F.3d at 651.[3]

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[3] *Amicus* also identified one public sector agreement that promised to "reimburse the retiree the cost of [the] individual TRS health insurance plan . . . for three (3) years after the effective date of the teacher's retirement" (*Board of Education, Schaumberg Community Consolidated School District 54 and*

D. Ambiguous Language: Statements of Continuity

14% of the sampled CBAs (6% private; 22% public) provide that benefits "will continue," but do not specify for how long or until when.

Here are two examples:

> The Authority will continue to provide for retirees of the New York State and Local Employees' Retirement System who have been employees of the Authority and who retired from the Authority (Retirees), the health and prescription drug insurance plans and options available to the Authority for Retirees through the New York State Health Insurance Program of the Civil Service Department (*Dormitory Authority of New York and UAW*, 3/31/11, 9190, http://goo.gl/VmHGw3).

And:

> Upon retirement, employees may remain in the same County group medical plan if immediately before their retirement they are either active subscribers to one of the County Health Plans . . . . (*Contra Costa County and*

Schaumburg Education Association, 6/30/12, 840049, http://goo.gl/3cJ2Zw). For the purposes of this study, *amicus* has grouped this provision with the age and Medicare-tying clauses. Both guarantee retiree health-care benefits for a specified amount of time, but do not vest them.

AFSCME, 9/30/05, 820527, http://goo.gl/VmHGw3).

The circuits disagree over how to interpret this language. The Sixth and Eighth Circuits deem it to create an ambiguity that should be resolved by reference to other contract provisions or extrinsic evidence. *Smith v. ABS Indus., Inc.*, 890 F.2d 841, 846 (6th Cir. 1989); *Anderson v. Alpha Portland Indus., Inc.* 836 F.2d 1512, 1519 n.4 (8th Cir. 1988). The Third and Seventh Circuits disagree. *Skinner Engine Co.*, 188 F.3d at 141; *Senn*, 951 F.2d at 816.

E. Silence

16% of the sampled CBAs (14% private; 18% public) do not include *any* of the above clauses that courts have construed as evidence whether benefits vest or are precluded from vesting.

Illustrative provisions are:

> Benefit coverage shall also be provided by the C&CWDC Welfare Fund and the C&CWDC Pension Fund to eligible retirees (*Independent Employer and Cement and Concrete Workers*, 6/3/05, 8705, http://goo.gl/D0Oz5S).

And:

> The Company will make available to retiring employees age 65 or older who retire after May 6, 2002, a Medicare Supplement, which will be completely employee paid (*Army Fleet Support and AFL-CIO*, 4/27/14, 3320, http://goo.gl/oJqcnv).

And:

> The District will, through HPN, assure that retirees who were enrolled in the Trust on July 31, 2001, and employees who retire thereafter shall have the opportunity to enroll in either the HPN HMO Plan or the HPN Senior Dimensions Medicare Risk Plan (for Medicare eligible) formerly offered to ESEA bargaining unit members (*Clark County School District and Education Support Employees Association*, 6/30/07, 820816, http://goo.gl/jYK77V).

III. Summary Plan Descriptions

The 100 CBAs reviewed and analyzed above relate most immediately to the Question Presented. But courts have also looked beyond the express terms of CBAs and (particularly in cases of ambiguity) "generally accord significant weight to representations made in" summary plan descriptions (SPDs). *See, e.g.*, *Golden*, 73 F.3d at 656. *Amicus* therefore analyzed the text of SPDs as well.

A. Methodology

As discussed in Part I, *supra*, *amicus* reviewed a total of 286 private-sector CBAs. For each, *amicus* sought to locate the corresponding SPD.[4] The vast majority of SPDs were not readily available. From the ones that were, *amicus* excluded SPDs that merely

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[4] The search for SPDs was limited to private-sector plans due to time constraints, and because this case involves such a plan.

state employers' obligations under COBRA or that discuss coverage for "qualified beneficiaries" without elaboration. Occasionally, multiple bargaining agreements would refer to the same health-care plan, and therefore to the same SPD—*e.g.*, the employees of both CBI Services and Tencon Inc. are party to the Boilermakers National Health and Welfare Fund. In these cases, *amicus* only recorded the SPD once.

This search revealed 39 SPDs that expressly discuss retiree health care. These 39 SPDs are logically divided into two categories: those that elaborate on express provisions in the CBA; and those that define benefits where the CBA is largely silent.

Only 5 SPDs fell in the first category, and relate to one of the fifty private CBAs that expressly provide for retiree health care. We call these "Elaborating" SPDs.

The other 34 SPDs relate to CBAs that provide health insurance, but the CBAs themselves do not discuss retiree eligibility. These CBAs refer to health-care plans or trust funds, but offer few details about the extent or quality of their coverage. We call these "Defining" SPDs. Representative examples of the health care provisions of the CBAs corresponding to Defining SPDs are:

> Employees will continue to be covered by University group insurance plans for the Supporting Staff employees, as modified below, provided that such coverage is contingent upon compliance with all existing requirements and conditions, including but not limited to, those which apply to employee eligibility and

> contributions (*Trustees of Columbia University and UAW/AFL-CIO*, 1/31/12, 9189, http://goo.gl/HEAoiR).

And:

> The Employer agrees to contribute five cents ($.05) per hour for up to forty (40) hours per week per employee . . . to the Retiree Health Plan to provide Retiree Health Benefits as may be determined by the Trustees of the Fund (*Great Atlantic and Pacific Tea Company and United Food and Commercial Workers*, 6/1/07, 6822, http://goo.gl/VKrM16).

And:

> All Employers referred to in paragraph (43) of this Article . . . accept and agree to be bound by the Agreement and Declaration of Trust, as hereinbefore and/or hereafter amended, establishing the: (a) Ohio Carpenters Health and Welfare Fund (*Associated General Contractors of Northwest Ohio and Ohio & Vicinity Regional Council of Carpenters*, 6/30/07, 8623, http://goo.gl/SLNWAL).

B. Provisions

Courts generally interpret language in SPDs in the same way as similar language in CBAs. This section will discuss the distribution of that language across both Elaborating and Defining SPDs. Note at the outset that although the language of the SPDs generally stated or strongly suggested that retiree health benefits do not vest, that does not necessarily suggest that it is generally accepted that such benefits

do not vest. That is because this language appears only in the subset of SPDs that expressly discuss the duration of those benefits; many other SPDs are silent on the issue. Moreover, because the sample of SPDs is substantially smaller than the sample of CBAs, inferences drawn from the sample may be less reliable.

1. *Express Statements of Intent:* Many SPDs explicitly state that retiree health benefits are not vested. 80% of the sampled Elaborating SPDs (4 out of 5) and 53% of Defining SPDs contain such unambiguous language. *Amicus* did not find any SPDs that describe retiree healthcare as "vested."

2. *Language Suggesting Vesting: Amicus* did not find any SPDs that provide for "lifetime" benefits. However, 100% of Elaborating descriptions and 79% of Defining descriptions tie retiree's eligibility for healthcare benefits to their pension status.

3. *Language Precluding Vesting:* 100% of both Elaborating and Defining SPDs contained a reservation of rights clause, granting either a company or an appointed Board of Trustees a full or significant ability to amend, alter, or terminate retiree health care benefits. Additionally, 20% of Elaborating SPDs and 26% of Defining SPDs provide benefits only until a retiree is eligible for Medicare.

Amicus did not find any SPDs that guarantee benefits only during the term of the bargaining agreement.

4. *Ambiguous Language or Silence: Amicus* did not find any SPDs that state benefits "will continue," but do not specify for how long or until when. Similarly,

none of the SPDs were silent on the duration of benefits.

5. *Miscellaneous: Amicus* identified one provision that is common in SPDs but absent from the above CBAs: the SPD provides that retiree health benefits will end if the base healthcare plan is terminated

A representative example of this clause is as follows:

> Coverage for a retired Employee and his or her dependents will terminate upon the occurrence of the first of the following events . . . on the date of discontinuance of the Senior Program or the Plan (*United Food and Commercial Workers Local 400 Health and Welfare Plan SPD*, http://goo.gl/txftEO).

50% of Defining SPDs include this language, which was absent from the Elaborating SPDs.

Amicus was unable to find any circuit precedent regarding this language.

FURTHER INFORMATION

Four data tables, formatted as worksheets in a Microsoft Excel workbook, accompany this brief. The first displays the explicit provisions contained in each private-sector collective bargaining agreement. The second displays the same with regards to public-sector agreements. The third outlines the provisions each of the 39 SPDs that discuss retiree healthcare benefits and also separates the plan descriptions into Elaborating and Defining SPDs. The fourth summarizes the results of the project, showing the distribution of provisions across document types. It

also highlights the key contrasts between private- and public-sector bargaining agreements.

These tables, which also include URLs for every CBA and SPD discussed in this brief, are available at *amicus*'s website: http://goo.gl/17MhsG.

CONCLUSION

Amicus hopes that the information in this brief will be helpful to the Court.

Respectfully submitted,

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v.
HOBERT FREEL TACKETT, ET AL., *Respondents*.

On Writ of Certiorari to the
United States Court of Appeals for the Sixth Circuit

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF AMICI CURIAE 1

SUMMARY OF ARGUMENT 1

ARGUMENT 4

I. The Expansion of Employer-Provided Retiree Health Benefits 8

A. Increased Availability of Retiree Coverage 8

B. Lowered Cost of Coverage 10

II. Reasons for Growth: Inexpensive and Useful Retiree Health Benefits 11

A. Modest Costs 12

B. Employer Gains 17

1. Collective Bargaining Gains 19

2. Workforce Management 20

CONCLUSION 22

Appendix A 1

TABLE OF AUTHORITIES

Page(s)

Cases

Bender v. Newell Window Furnishings, Inc.,
681 F.3d 253 (6th Cir. 2012).....6

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INTEREST OF AMICI CURIAE[1]

Amici curiae are the professors of labor and employee benefits law listed in Appendix A. *Amici* have an interest in the sound development of the legal principles that guide the interpretation of collective bargaining agreement (CBA) provisions promising employer-sponsored health benefits to retirees.

Amici submit this brief to provide information regarding the legal and factual landscape in which employers operated when they originally agreed to extend ongoing health benefits to their retirees. *Amici* believe this information may assist the Court because it explains why employers reasonably negotiated a range of agreements about retiree health insurance, including agreements that promised retirees health benefits for life.

SUMMARY OF ARGUMENT

Petitioners and their *amici* argue that employers were and continue to be unlikely to grant vested retiree health benefits because of the potential for those benefits to become unpredictably expensive over time. Accordingly, they argue that a court should determine that retiree health benefits

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[1] No counsel for a party authored this brief in whole or in part, and no counsel for a party made a monetary contribution intended to fund the preparation of this brief. No person other than the *Amici Curiae* or their counsel made a monetary contribution to the preparation or submission of this brief. Letters evidencing the parties' consent to the filing of *amicus* briefs are on file with the clerk.

are vested only if the relevant CBA contains a clear statement to that effect.

Whether or not this assessment of employer reasoning is correct today, it is seriously flawed as to the period of time during which many retiree health benefits clauses were first negotiated: the mid-1960s through mid-1970s. Moreover, because the language governing retiree health insurance has often been carried, basically unchanged, from CBA to CBA, the conditions surrounding initial negotiations remain relevant to interpretation of CBA language today.

The mid-1960s to mid-1970s saw a surge in employer-provided retiree health insurance. For example, by 1974, nearly three-quarters of employer-sponsored health plans extended coverage to retirees—a significant increase from the early 1960s. Employer-provided retiree health benefits also became more generous during this time, shifting from a model in which retirees were usually responsible for the entire cost of their health insurance to one in which employers frequently paid the entire cost of that coverage.

Two important reasons explain this trend, and they also explain why employers in the 1960s and 1970s reasonably negotiated retiree health benefits that were intended to vest. First, retiree health insurance during this period was inexpensive; indeed, some employers considered the cost of these benefits to be *de minimis*. This was in part because there were fewer retirees to receive coverage; compared to today, employees tended to work until an older age, and life expectancy was shorter. In addition, in 1966, Medicare began picking up much

of the cost of health care for retirees age 65 or older. Moreover, there was little reason for employers to grapple with the possibility that benefits would become more expensive in the long term because they funded health benefits on a pay-as-you-go basis.

Second, extending retiree health benefits allowed employers to achieve other workplace management goals. These goals could be as straightforward as reaching agreement with a labor union: When retiree health insurance was inexpensive, there would have been few reasons for an employer to "hold out" over that issue in bargaining. Further, employers could use retiree health benefits as a retirement incentive in order to thin employee ranks without violating the Age Discrimination in Employment Act. That incentive would have been particularly critical in appealing to employees who were still years from qualifying for Medicare. However, retiree health benefits that lasted for only the term of the CBA in which they were negotiated would have meant little to such employees.

In sum, many contracts promising retiree health benefits were first negotiated in a context that differed dramatically from the one that exists today. In that context, it would have been eminently reasonable for employers to agree to vest retiree health benefits in order to manage their workforces and to reach agreement with unions at relatively little cost.

ARGUMENT

This case concerns the interpretation of CBA provisions that promise retiree health benefits without clearly indicating the duration of those benefits. In this and many other similar cases, the CBAs at issue either fail to address or are ambiguous as to whether coverage under an employer-sponsored health insurance plan becomes nonforfeitable—in more technical terms, "vested"—when a worker terminates active employment and becomes eligible for retiree health benefits under that plan.

This brief offers an historical account explaining why many employers expanded retiree health benefits coverage from the mid-1960s through the mid-1970s. In short, many employers regarded these benefits as inexpensive and therefore easy to grant. Moreover, employers could use retiree health benefits to obtain collective bargaining concessions from unions and to encourage older workers to retire. And, employers were far more likely to achieve these goals by agreeing to vested retiree health benefits, rather than offering benefits that would expire at the end of a single CBA term.

Despite this history, Petitioners and their *amici* argue that this Court should adopt the approach taken by the Third Circuit in *Int'l Union, UAW v. Skinner Engine Co.* 188 F.3d 130 (3d. Cir. 1999). *Skinner Engine* held that "because . . . vesting of welfare plan benefits constitutes an extra-ERISA commitment, an employer's commitment to vest benefits is not to be inferred lightly and must be

stated in clear and express language." *Id.* at 139. In arriving at this conclusion, *Skinner Engine* emphasized both that retiree health benefits are not statutorily vested by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 ("ERISA"), and that the cost of these benefits over time is unpredictable. 188 F.3d at 138 (stating that "Congress recognized the need for flexibility with respect to an employer's right to change medical plans" because "the costs of such plans are subject to fluctuating and unpredictable variables") (internal quotation marks and citation omitted). These two "cautionary principles" led the *Skinner Engine* court to conclude that neither congressional policy nor employer incentives suggested employers were likely to have agreed to vest retiree health benefits absent clear language to the contrary. Or, as two of Petitioners' *amici* put it, "there is no reason to presume that an employer would agree *sub silentio* to such a costly and open-ended commitment." Br. of the ERISA Indus. Comm. & the Am. Benefits Council as *Amici Curiae* in Support of Pet. at 5.[2]

Today, with retirees living longer and constant improvements in healthcare technologies driving costs upward, employers may indeed be resistant to introducing lifetime retiree health insurance. However, very few of today's employer-

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[2] Petitioners and their other *amici* advance similar claims. *See* Pet. Br. at 25-26; Br. of the Council on Labor Law Equality & the Soc'y for Human Res. Mgmt. as *Amici Curiae* in Support of Pet. at 8-9 & 21n.6; Br. for the Chamber of Commerce of the USA & the Business Roundtable as *Amici Curiae* in Support of Pet. at 4.

sponsored retiree health plans are new creations. Instead, the key provisions of these plans were typically negotiated long ago. Moreover, CBA clauses regarding retiree healthcare are commonly carried from initial agreements into subsequent ones largely unchanged by either side during negotiations.[3] *See, e.g., Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 262-63 (6th Cir. 2012) (noting that CBAs repeated language over course of more than two decades, with additions in only two agreements); *Quesenberry v. Volvo Trucks North America Retiree Healthcare Benefit Plan*, 651 F.3d 437, 438 (4th Cir. 2011) (highlighting identical retiree health provisions in CBAs from 1984 through 2005); *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 575 (6th Cir. 2006) (noting that language of CBAs and group insurance plans remained "substantially unchanged" over two decades); *Maurer v. Joy Techs., Inc.*, 212 F.3d 907, 911-14 (6th Cir. 2000) (describing similar or identical CBA language regarding retiree health benefits over multiple agreements); *Skinner Engine*, 188 F.3d at

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[3] Of particular relevance to this case, retiree health provisions in CBAs covering rubber industry employees can often be traced back several decades. *See, e.g., Redington v. Goodyear Tire & Rubber Co.*, No. 5:07-cv-1999, 2008 WL 3981461, at *3 (N.D. Ohio Aug. 22, 2008) (referring to example agreements from 1976 and 1979); *Groover v. Michelin N. America, Inc.*, 90 F.Supp. 2d 1236, 1240 (M.D. Ala. 2000) (discussing series of fourteen CBAs, all of which "contain similar provisions affording medical benefits to retirees and surviving spouses of retirees"); *United Rubber, Cork, Linoleum & Plastic Workers of Am. v. Pirelli Armstrong Tire Corp.*, 873 F.Supp. 1093, 1096-98 (M.D. Tenn. 1994) (describing string of CBAs dating to 1950s, which company represented "provided lifetime health benefits to retirees").

135 (observing that series of CBAs contained retiree benefits clauses with "substantially similar language"); *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, 1067 (6th Cir. 2008) (observing that "core language regarding retiree healthcare coverage remained essentially unchanged" over course of twelve CBAs).

As explained below, the history and the continuity of these agreements undermine the *Skinner Engine* court's conclusion that employers were unlikely to have agreed to vest retiree health benefits, which in turn led that court to require clear CBA language before it would find vesting had occurred. Contrary to that conclusion, during a key period in the expansion of retiree health benefits—the decade or so from approximately the mid-1960s through the mid-1970s—employers generally considered retiree health insurance to be an inexpensive benefit, a useful bargaining chip, and a convenient tool to accomplish other management goals such as voluntary workforce reduction. Under those circumstances, many employers readily granted retiree health benefits. Moreover, at least some employers appear not to have considered the possibility that the benefits might eventually become significantly more expensive; instead, they focused on short- and medium-term goals that might be accomplished by granting retiree health benefits, particularly if those benefits were vested.

I. The Expansion of Employer-Provided Retiree Health Benefits

The 1960s and 1970s are critical years in understanding the development of employment-based retiree health benefits because many employers extended health insurance to retirees for the first time during those years. By the mid-1970s, retiree health benefits had become widespread and generous.

A. Increased Availability of Retiree Coverage

Employer-sponsored health insurance for active employees expanded rapidly in the United States after World War II. *See* Colin Gordon, *Dead on Arrival* 21 (2003) (reporting that at least two-thirds of employers with more than 250 employees, and more than 50% of smaller employers, sponsored health insurance plans by the late 1940s). Employment-based health coverage for retirees, however, developed more slowly. A Social Security Bulletin review of benefit plans in the 1950s observed a "trend toward making advance arrangements" for retiree health insurance, and the Bureau of Labor Statistics reported that the number of collectively bargained plans offering retiree health benefits almost doubled from 1955 to 1959. Alfred M. Skolnik, *Trends in Employee-Benefit Plans, 1954-59: Part 1*, 24 Soc. Sec. Bull., Apr. 1961, at 5, 16 (hereinafter Skolnik, *Trends*). Even so, studies conducted in the early 1960s showed the percentage of active employees with some type of retiree health coverage available increased from 29 percent in 1960

to 33 percent in 1962, then fell back to 25 percent in 1963. Alfred M. Skolnik, *Employee-Benefit Plans: Developments, 1954-63,* 28 Soc. Sec. Bull., Apr. 1965, at 10 (observing that "[p]rogress in recent years has been less clear cut with respect to the practice of continuing the health insurance coverage of retired workers").

Despite their uneven start, retiree health benefits became far more widely available in the latter half of the decade. A 1968 study of 98 large, collectively bargained plans found that "3 out of 5 plans" had extended retiree health benefits. Walter W. Kolodrubetz, *Employee-Benefit Plans, 1950-67,* 32 Soc. Sec. Bull., Apr. 1969, at 4 (hereinafter Kolodrubetz, *Employee-Benefit Plans*). Then, a 1974 study found that fully 71 percent of employer-sponsored health plans extended coverage to retirees over age 65, and by 1975 the Social Security Bulletin reported that "[m]ost group health plans permit continuation of coverage after retirement" in some form. Alfred M. Skolnik, *Twenty-Five Years of Employee-Benefit Plans,* 39 Soc. Sec. Bull., Sept. 1976, at 16 (hereinafter Skolnik, *Twenty-Five Years*).

After that, the pace of growth stabilized before eventually reversing. By 1988, the last year before retiree health plan availability began to decline, about two-thirds of large employers offered some form of health insurance to their former employees. Kaiser Family Found./Health Research & Educ. Trust, *2013 Emp. Health Benefits Survey*, Exh. 11.1 (2013), http://kff.org/report-section/ehbs-2013-section-11/ (surveying both public and private employers with 200 or more employees).

B. Lowered Cost of Coverage

The number of retirees who can claim employer-provided health benefits is just one aspect of the overall picture of these benefits. Another key aspect is the cost of coverage—in other words, the extent to which retirees are required to pay for their own benefits. But the story is similar: By the late 1960s, employers were offering retirees health insurance on increasingly generous terms.

Retiree health benefit packages initially tended to be far more restrained than those available to active employees. For example, although the Detroit automakers began in 1953 to allow retirees age 65 or older to purchase the same health insurance available to active employees, the companies charged retirees the full price of that coverage. Jill Quadagno, *One Nation, Uninsured* 148 (2005) (hereinafter Quadagno, *One Nation*). The American auto industry was not alone in this approach. In 1959, 80 percent of employers offering coverage under collectively bargained plans imposed different contribution requirements on retirees than active employees, with 75 percent requiring retirees to pay the entire premium for retiree coverage; employers also controlled retiree plan costs by imposing lifetime benefit limits and restricting available services. Skolnik, *Trends*, 24 Soc. Sec. Bull., Apr. 1961, at 16.

By the late 1960s, not even a decade later, much had changed. A 1968 study of 98 large, collectively bargained plans reported that "about 85

percent . . . were financed in full by the employer." Kolodrubetz, *Employee-Benefit Plans*, 32 Soc. Sec. Bull., Apr. 1969, at 4. Similarly, a 1973 National Industrial Conference Board study found that, "[i]n most cases where the company was providing the employee's own coverage before retirement free of charge, this policy was continued." Skolnik, *Twenty-Five Years*, 39 Soc. Sec. Bull., Sept. 1976, at 16. When the U.S. Census Bureau conducted a survey in 1988 of retiree health coverage, it found that employers were paying 100 percent of premium costs for 42 percent of covered retirees and at least some of the premium costs for another 33 percent of retirees. U.S. Dep't of Labor, *Retirement Benefits of American Workers: New Findings from the September 1994 Current Population Survey*, Tbl. E9 (Sept. 1995).

II. Reasons for Growth: Inexpensive and Useful Retiree Health Benefits

Contrary to the premise of the *Skinner Engine* court as well as the Petitioners and their *amici*, when retiree health benefits were introduced, they could often serve as relatively inexpensive methods of achieving other employer goals, such as reaching agreement with labor unions during bargaining or encouraging employees to retire. Thus, employers agreed to extend health insurance to their retirees in an era when many of those employers believed retiree health benefits created a big bang for few bucks. In other words, employers could promise retirees something the retirees would consider valuable, but at low cost, and in return achieve

several worker management goals—in many ways the perfect benefit for both sides.

Of course, not all employers who negotiated retiree health benefits during the 1960s and 1970s intended those benefits to vest. However, the contention that few employers ever would have agreed to vest retiree health benefits, and that therefore courts should be loathe to find vesting, is equally untenable.

A. Modest Costs

Unlike today's health benefits, retiree health benefits were viewed as inexpensive when they were added to employee compensation packages in the 1960s and 1970s. At least two facts explain this phenomenon: First, there were then fewer retirees, and they did not receive benefits for as long as retirees typically do today; and, second, Medicare was enacted in 1965 and began absorbing much of the cost of healthcare for retirees age 65 and older. Accordingly, it is unsurprising that, while at least some employers undoubtedly recognized the potential for costs to increase in subsequent decades, retiree healthcare expenditures in general did not draw much attention almost fifty years ago.

As Michael S. Gordon, often described as one of ERISA's architects, put it:

> Unlike pension plans, there was no crisis in health plans in 1974 . . . . Nor was there evidence of potentially out-of-control medical cost inflation, nor of new and dramatically high-priced medical technologies, the use of

> which would become the norm, rather than the exception . . . . [E]mployer-provided health insurance was cheap and plentiful.

Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century, in Employee Benefits Law* lxviii (Steven J. Sacher et al. eds., 2d ed. 2000). Not only does this provide insight into why ERISA at the outset primarily focused on pension benefit plans rather than welfare benefit plans, it also explains why employers might have agreed to vest retiree health benefits: In contrast to the relatively determinate costs they were committing to retirement plans, the cost of future retiree health insurance simply seemed insignificant.

This may be remarkable from today's vantage point, but retiree health care benefits in earlier decades were perceived as so inexpensive that one employee benefits counsel later described them as virtually costless to employers: "[I]n order to obtain the employer's business in covering active employees, the insurance companies often agreed to cover retirees without additional cost to the employer. Needless to say, many employers accepted the offer." Interview by Editor with Steven J. Sacher, Jones Day, *VEBAs—The Answer to Healthcare Benefit Costs for Retirees?*, Metro. Corp. Counsel, Feb. 2008, at 49. Others have confirmed this report, characterizing retiree health insurance "as a goodwill gesture and an inexpensive addition to the total retirement package." *See, e.g.*, Anna M. Rappaport & Carol H. Malone, *Adequacy of Employer-Sponsored Retiree Health Benefit*

Programs, in Providing Health Care Benefits in Retirement 60 (Judith F. Mazo et al. eds., 1994).

Even if not always without cost, retiree health plans before the 1980s would have been comparatively inexpensive because of active workers' and retirees' demographics. In 1960, approximately 14.26 million individuals were receiving Social Security benefits (including retirement, disability, and survivors' benefits); by 1980, that number had reached 35.12 million. Social Security Administration, *Ratio of Social Security Covered Workers to Beneficiaries Calendar Years 1940-2010*, Social Security Online, http://www.ssa.gov/history/ratios.html. Similarly, in 1960, only 9.2 percent of the U.S. population was age 65 or older; by 1980, 11.3 percent of the population was at least age 65. Frank Hobbs & Nicole Stoops, U.S. Census Bureau, *Demographic Trends in the 20th Century*, Fig. 2-4 (Nov. 2002), http://www.census.gov/prod/2002pubs/censr-4.pdf. Thus, in the 1960s and 1970s, there were simply fewer retirees, both in absolute terms and as compared to active workers, than there are today.

Further, workers in the early 1960s tended to stay employed until at least age 65. For the five-year period from 1960 to 1965, based on Social Security data, the median age for retirement was 65; by the five-year period from 1980 to 1985, the median age for leaving the workforce had dropped to slightly below age 63. Murray Gendell, *Retirement Age Declines Again in 1990s,* 124 Monthly Lab. Rev., Oct. 2001, at 14. In addition, life expectancy in the U.S. has increased since 1960. An individual who

was 65 years old in 1959-1961 could be expected to live an average of 14.3 more years, whereas an individual who reached age 65 in 1979-1981 could be expected to live an average of 16.5 more years. Elizabeth Arias, *United States Life Tables, 2009,* 62 Nat'l Vital Statistics Reports, Jan. 16, 2014, at 51, Tbl. 21. Taken together, this statistical trifecta (a lower proportion of older Americans in the 1960s, who worked longer and did not live as long as workers who reached age 65 in later years) explains why there were simply fewer individuals eligible for employment-based retiree health benefits during the same two decades when employers were contemplating both expanding the availability of these benefits and assuming a higher percentage of the premium expense.

Retiree health insurance became even less expensive for employers with the 1965 enactment of Medicare. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965). Medicare provides generous health insurance coverage for the vast majority of the U.S. population age 65 and older. *See generally* Marilyn Moon, *Medicare: A Policy Primer* (2006). Once Medicare took effect in 1966, employers quickly realized they could "offer health benefits to their retirees with the assurance that the Federal Government would pay for many of the medical costs incurred by company retirees age 65 and older." Special Comm. on Aging, U.S. Senate, *Developments in Aging: 1996*, S. Rep. No. 105-36, at 191 (1997). Employer plans would generally coordinate with Medicare, acting as supplemental rather than primary insurance. Louis S. Reed & Kathleen Myers, *Health Insurance Coverage*

Complementary to Medicare, 30 Soc. Sec. Bull., Aug. 1967, at 6, 9. With Medicare shouldering the bulk of the healthcare costs for most retirees age 65 and older, employers could afford to be generous in extending coverage. In some cases, the presence of Medicare meant that employers were willing to offer retiree health benefits for the first time, including negotiating coverage for hourly retirees of certain Medicare premiums and deductibles. Kathleen Myers, *Employee-Benefit Plan Adjustments to Health Insurance for the Aged*, 29 Soc. Sec. Bull., July 1966, at 23 (hereinafter Myers, *Employee-Benefit Plan Adjustments*). In other cases, the Medicare foundation encouraged employers to expand existing coverage.[4]

Employers could also be unconcerned about future retiree health plan costs because they typically funded retiree benefits on a pay-as-you-go basis just as they did active employee health insurance. *Cf.* Fin. Accounting Standards Bd., *Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions*, 167 (1990). In other words, as long as an employer had enough cash to meet the annual premium expense, there was no incentive for that employer to worry about future

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[4] For example, Medicare's enactment prompted Ohio Bell Telephone Company, which already offered retiree health coverage, to negotiate with the Communications Workers of America to increase retiree health benefits that coordinated with Medicare. That contract then became the Communications Workers model agreement for other employer plan negotiations. Myers, *Employee-Benefit Plan Adjustments*, 29 Soc. Sec. Bull., July 1966, at 24.

costs. Not until the early 1990s did private sector employers face any kind of required financial statement disclosure of long-term retiree health benefit commitments. *Id.* at 9 (promulgating new accounting requirement for retiree health benefits generally effective for fiscal years beginning after December 15, 1992). While employers today could not be so relaxed, employer choices in the 1960s and 1970s reflected a markedly different vision. "With relatively few retirees, comparatively small health benefit costs, and a philosophy that American manufacturing would dominate world markets forever, the idea of financing retiree health from future income seemed reasonable." G. Lawrence Atkins, *The Employer Role in Financing Health Care for Retirees, in Providing Health Care Benefits in Retirement* 108 (Judith F. Mazo et al. eds., 1994).[5]

Given all this, it is not surprising that many employers found retiree health benefits relatively easy to grant at the outset. Retiree health insurance developed in a time when costs and risks appeared small. Far from expensive benefit programs to which few reasonable employers would commit, as envisioned by the *Skinner Engine* court, retiree health plans at their inception instead appeared as a comparatively inexpensive means of obtaining desired outcomes.

B. Employer Gains

"Retiree health benefits, like other benefits and compensation, are provided because they help

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[5] G. Lawrence Atkins was at the time the Director of Health Legislative Affairs at Winthrop, Stimson, Putnam & Roberts.

the organization achieve its human resource goals." William M. Mercer-Meidinger-Hansen, Inc., *Retiree Health Benefits: Plan Designs for a Changing World, in Employee Welfare Benefit Plans 1989*, 74 (PLI 1989). Put another way, employers "gain from offering retiree benefits if, by doing so, (1) the firm can elicit certain desirable behaviors from its workers, and (2) the advantages of providing the benefits exceed their costs." Olivia S. Mitchell, *Commentary, in Providing Health Care Benefits in Retirement*, 44 (Judith F. Mazo *et al.* eds., 1994). While some employers may have offered retiree health benefits out of altruism,[6] especially given their low cost as described in the previous section, many employers undoubtedly agreed to these benefits for other purposes. The following subsections describe two major employer goals served by extending retiree health benefits: first, obtaining leverage in collective bargaining; second, workforce management. Significantly, employers would have found it far more difficult to obtain these goals had they granted only retiree health benefits that expired at the end of a single CBA.

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[6] For example, Eastman Kodak's policies toward health insurance for both active employees and retirees were so generous that the company was characterized as a "doting uncle." Milt Frudenheim, *A Doting Uncle Cuts Back, and a City Feels the Pain*, N.Y. Times, Oct. 8, 1995, at C1. Retirees received entirely employer-funded health insurance, with no restrictions on providers, until the company's financial problems caused it to implement various cost-control measures. Although likely not the best explanation for most employers, it is at least possible that some—like Kodak—took seriously the vision of a caring cradle-to-grave relationship with longtime employees.

1. Collective Bargaining Gains

Collective bargaining can have a tit-for-tat quality in piecing together employee benefits packages. As described earlier, employers in the 1960s and early 1970s considered retiree health insurance a low-cost benefit. Accordingly, it became a bargaining chip that could be exchanged for concessions from unions. Indeed, many employers "viewed retiree health benefits as a 'throw-away' issue in the employee benefits bargaining process." U.S. Gen. Accounting Office, *Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System*, Report No. GAO/HRD-93-125, at 1 (1993).

With employers on one side viewing retiree health benefits as an easy item to give, and "strong unions and aggressive bargaining" on the other side, interests aligned to support expansion. Joan Vogel, *Until Death Do Us Part: Vesting of Retiree Insurance,* 9 Indus. Relations L. J. 183, 199 (1987). In addition, employers sometimes negotiated agreements in which active workers deferred planned wage increases in order to offset the costs of retiree health benefits to the employer. *E.g., Cole v. ArvinMeritor, Inc.*, 516 F.Supp. 2d 850, 854-55 (E.D. Mich. 2005) (explaining that under 1962-1965 CBA one or two cents of planned wage increases would be diverted to fund retiree health benefits). Thus, retiree health benefits were (and remain) a two-way street, with unions and active workers making concessions in exchange for the insurance commitment. *E.g., Carbon Fuel Co. v. USX Corp.*, 100 F.3d 1124, 1129 (4th Cir. 1996) (noting that Coal Commission found employer signatories to CBA had

"benefitted from UMWA concessions in exchange for better [retiree] healthcare benefits").

2. Workforce Management

Moreover, some employers viewed retiree health benefits as a workforce management tool. Passage of the Age Discrimination in Employment Act of 1967 ("ADEA"), Pub. L. No. 90-202, 81 Stat. 602 (1967), and the risk of age discrimination lawsuits meant employers seeking to reduce payroll expenses could not target workers who were at least 40 but not yet 65 years old even though such older workers were typically paid more; the statute was amended in 1978 to include workers up to age 70 in the protected group. Age Discrimination in Employment Act Amendments of 1978, Pub. L. No. 95-256, § 2(a), 92 Stat. 189, 189 (1978). However, the ADEA gave employers an out, allowing age-related distinctions and eligibility provisions to be included in a "bona fide employee benefit plan such as a retirement, pension or insurance plan, which is not a subterfuge to evade the purposes of the Act." 29 U.S.C. § 623(f)(2) (1986). By the mid-1970s, corporations had begun to structure early retirement incentive programs ("ERIPs") to meet the ADEA bona fide employee benefit plan exception. *See generally* Richard G. Kass, *Early Retirement Incentives and the Age Discrimination in Employment Act*, 4 Hofstra Lab. L.J. 63 (1986).[7]

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[7] Studies in the mid-1980s found that about a third of employers had offered at least one early retirement window since the early 1970s. *See* Donald Bell & William Marclay, *Trends in retirement eligibility and pension benefits, 1974-83*,

Depending on an employer's goals, ERIPs could include lowered age and service requirements for pension eligibility as well as retiree health benefits. The idea was to encourage older workers to leave active employment voluntarily, sidestepping ADEA concerns. *See* Jill S. Quadagno & Melissa Hardy, *Regulating Retirement through the Age Discrimination in Employment Act*, 13 Res. on Aging 470, 472 (1991); Quadagno, *One Nation*, *supra*, at 149 (2005). Retiree health plans could be a key part of these incentive packages. Donald T. Weckstein, *The Problematic Provision and Protection of Health and Welfare Benefits for Retirees*, 24 San Diego L. Rev. 101, 105 (1987). Because early retirees would generally not qualify for Medicare coverage until they reached age 65, they needed a health insurance bridge between active employee coverage and Medicare. Employment-based retiree health plans built that bridge. Accordingly, the popular press later characterized ERIPs as a way for employers to "open up management ranks, to thin out an overstaffed organization or to meet recessionary pressures without resorting to layoffs." Elizabeth M. Fowler, *Careers; The Early Retirement Programs*, N.Y. Times, Apr. 25, 1984, at D21.

Such workforce realignment goals further explain why some employers would have been willing to extend retiree health insurance beyond the duration of individual CBAs. ERIPs were effective only if they could entice older workers to retire,

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110 Monthly Lab. Rev., Apr. 1987, at 25; Diane E. Herz & Philip L. Rones, *Institutional barriers to employment of older workers*, 112 Monthly Lab. Rev., Apr. 1989, at 18.

relinquishing the benefits available to active employees—benefits that would, as a practical matter, certainly include health insurance during the entire term of active employment. If the promise of continuing health insurance in retirement lasted only as long as the CBA term, the value of that key retirement incentive would be much diminished. This would be especially true for potential retirees yet too young to qualify for Medicare. In light of the then-prevailing view of retiree health insurance as inexpensive, employers could be better off in the short- and medium-term when they agreed to lifetime retiree health benefits; moreover, they did not necessarily have either the foresight or the incentives to predict the long-term picture.

While these dynamics do not indicate that any individual contract was intended to vest retiree health benefits, they do illustrate the shortcomings of the one-size-fits-all approach embraced by the *Skinner Engine* court and advocated by Petitioners and their *amici*. That approach relies on assumptions that might hold today, but that do not accurately reflect the era in which the terms of most retiree health plans—terms that for many plans have persisted over the decades largely unchanged—were negotiated. This Court should not adopt that ahistorical approach.

CONCLUSION

For the foregoing reasons, this Court should reject the Petitioners' invitation to adopt the Third Circuit's approach and should not require a clear statement of intent before holding that retiree health benefits are vested.

Respectfully submitted,

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Appendix

Appendix A

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AMICUS CURIAE BRIEF

RECORD
AND
BRIEFS

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In the Supreme Court of the United States

M&G POLYMERS USA, LLC, *ET AL.*,
Petitioners,

v.

HOBERT FREEL TACKETT, *ET AL.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iv

INTERESTS OF *AMICUS CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. THE "CLEAR AND EXPRESS LANGUAGE" RULE FOR JUDGING WHETHER RETIREE HEALTH BENEFITS ARE VESTED WOULD SERVE THE CONGRESSIONAL INTENT AND PROMOTE GREATER CERTAINTY FOR EMPLOYERS, UNIONS, AND RETIREES 5

A. Congress Made a Conscious Decision Not To Mandate Vesting of Welfare Benefits, Including Retiree Health Care Benefits 6

B. The *Yard-Man* Inference Used by the Court Below Frustrates the Congressional Intent and the Expectations of Bargainers 10

1. The *Yard-Man* Inference and Its Corollary Rules of Construction Foreclose Argument on Vesting 10

2. The *Yard-Man* Inference and Its Corollaries Are Not Well-Reasoned 16

C. A Rule Requiring "Clear and Express Language" in the CBA for Vesting of

Retiree Health Benefits Best Effectuates Congressional Intent. 19

D. The Second and Seventh Circuit Approaches Provide Insufficient Certainty and May Lead to Extensive Litigation. 22

II. THE INFERENCE OF VESTED RETIREE HEALTH BENEFITS IMPOSES A SEVERE AND INTRACTABLE BURDEN ON EMPLOYERS. 25

A. Vested Retiree Health Benefits Impose a Huge Financial Cost on the Employer. 25

B. The *Yard-Man* Rule Undermines Attempts by Employers To Negotiate Reductions in Vested Retiree Health Benefits. 29

C. Under *Yard-Man*, Bankruptcy May Be the Only Effective Resort for Employers To Reduce Vested Retiree Health Benefits. 31

III. THE "CLEAR AND EXPRESS LANGUAGE" RULE WOULD BENEFIT EMPLOYERS, UNIONS, AND COURTS. 33

A. A Clear Rule Would Promote More Effective Collective Bargaining. 33

B. The "Clear and Express Language" Rule Would Reduce Future Litigation and Forum Fights. 34

CONCLUSION 36

TABLE OF AUTHORITIES

Cases

Accenture, L.L.P. v. Wellogix, Inc.,
134 S. Ct. 2725 (2014) 2

Allied Chemical & Alkali Workers of America v. Pittsburgh Plate Glass Co.,
404 U.S. 157 (1971) 18

Am. Federation of Grain Millers v. Int'l Multifoods Corp.,
116 F.3d 976 (2d Cir. 1997) 22, 24

Anderson v. Alpha Portland Indus., Inc.,
836 F.2d 1512 (8th Cir. 1988) 21

Argentina v. NML Capital, Ltd.,
134 S. Ct. 2250 (2014) 1

Armistead v. Vernitron Corp.,
944 F.2d 1287 (6th Cir. 1991) 14

Baldwin v. Motor Components, L.L.C.,
155 F. App'x 16 (2d Cir. 2005) 22, 24

Barnett v. Ameren Corp.,
436 F.3d 830 (7th Cir. 2006) 23, 24

Bender v. Newell Window Furnishings, Inc.,
681 F.3d 253 (6th Cir. 2012) 8, 14

Bialoszynski v. Milwaukee Forge,
419 F. Supp. 2d 1045 (E.D. Wis. 2006) 24

Bidlack v. Wheelabrator Corp.,
993 F.2d 603 (7th Cir. 1993) 22, 24

Bittinger v. Tecumseh Prods. Co.,
123 F.3d 877 (6th Cir. 1997) 14

Boeing Co. v. March,
656 F. Supp. 2d 837 (N.D. Ill. 2009) 24

Bowen v. Massachusetts,
487 U.S. 879 (1988) 35

Carnagua v. Link-Belt Co.,
No. 1:04-CV-1566-LJM-JMS, 2007
WL 2904544 (S.D. Ind. Sept. 28,
2007) 24

Cherry v. Auburn Gear, Inc.,
441 F.3d 476 (7th Cir. 2006) 23, 24

CNH Am. LLC v. UAW,
645 F.3d 785 (6th Cir. 2011) 30

Cole v. ArvinMeritor, Inc.,
549 F.3d 1064 (6th Cir. 2008) 14

Conn. Indep. Util. Workers Local 12924
v. Conn. Nat. Gas Corp.,
No. 3:12CV961 JBA, 2014 WL
941805 (D. Conn. Mar. 11, 2014) 24

CTS Corp. v. Waldburger,
134 S. Ct. 2175 (2014) 1

Curtiss-Wright Corp. v. Schoonejongen,
514 U.S. 73 (1995) 6

Diehl v. Twin Disc, Inc.,
102 F.3d 301 (7th Cir. 1996) 22, 24

Enright v. N.Y .City Dist. Council of Carpenters Welfare Fund, No. 12 CIV. 4181 JPO, 2013 WL 3481358 (S.D.N.Y. July 10, 2013) 24

Exxon Mobil Corp. v. City of New York, 134 S. Ct. 1877 (2014) 2

Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459 (2014) 1

GenOn Power Midwest, L.P. v. Bell, 134 S. Ct. 2696 (2014) 2

Golden v. Kelsey-Hayes Co. (In re Golden), 73 F.3d 648 (6th Cir. 1996) 12, 14

Halliburton v. Erica P. John Fund, Inc., 134 S. Ct. 2398 (2014) 1

Hertz Corp. v. Friend, 559 U.S. 77 (2010) 35

Int'l Chem. Workers Union v. PPG Indus., Inc., 236 F. App'x 789 (3d Cir. 2007) 21, 24

Int'l Union, UAW v. BVR Liquidating, Inc., 190 F.3d 768 (6th Cir. 1999) 14, 16

Int'l Union, UAW v. Cadillac Malleable Iron Co., 728 F.2d 807 (6th Cir. 1984) 13, 14

Int'l Union, UAW v. Chrysler LLC, No. 07-CV-14310, 2008 WL 2980046 (E.D. Mich. July 31, 2008) 28

Int'l Union, UAW v. Rockford Powertrain, Inc.,
350 F.3d 698 (7th Cir. 2003) 23, 24

Int'l Union, UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) ..... *passim*

Int'l Union, UAW v. Yard-Man, Inc.,
716 F.2d 1476 (6th Cir. 1983) ..... *passim*

Integrity Staffing Solutions, Inc. v. Busk,
134 S. Ct. 1490 (2014) 1

Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry.,
520 U.S. 510 (1997) 6

Joyce v. Curtis-Wright Corp.,
171 F.3d 130 (2d Cir. 1999) 22, 23, 24

Leahy v. Page Eng'g Co.,
No. 89 C 9577, 1992 WL 51710 (N.D. Ill. Mar. 10, 1992) 24

Leannah v. Alliant Energy Corp.,
607 F. Supp. 2d 946 (E.D. Wis. 2009) 24

Lewis v. Allegheny Ludlum Corp.,
No. CIV. A. 11-1619, 2012 WL 1328360 (W.D. Pa. Apr. 17, 2012) 25

Litton Financial Printing Division v. NLRB,
501 U.S. 190 (1991) 8

Local 56, UFCWU v. Campbell Soup Co.,
898 F. Supp. 1118 (D.N.J. 1995) 25

Local Lodge 470 of Dist. 161 v. PPG Indus., Inc.,
No. CIV.A. 01-2110, 2006 WL 901927 (W.D. Pa. Mar. 31, 2006) 24

Maurer v. Joy Techs., Inc.,
212 F.3d 907 (6th Cir. 2000) 13, 14

McCoy v. Meridian Auto. Sys., Inc.,
390 F.3d 417 (6th Cir. 2004) 14

Moore v. Menasha Corp.,
690 F.3d 444 (6th Cir. 2012) 12, 14

Moore v. Metro. Life Ins. Co.,
856 F.2d 488 (2d Cir. 1988) 7

Murphy v. Keystone Steel & Wire Co.,
61 F.3d 560 (7th Cir. 1995) 23, 24

Noe v. PolyOne Corp.,
520 F.3d 548 (6th Cir. 2008) 14, 15, 17

North Dakota v. EPA,
134 S. Ct. 2662 (2014) 2

Oakley v. Remy Int'l, Inc.,
795 F. Supp. 2d 810 (S.D. Ind. 2011) 24

Oil, Chem., Atomic Workers' Int'l Union v. Amoco Corp.,
No. 93 C 5929, 1997 WL 11233 (N.D. Ill. Jan. 9, 1997) 24

Oklahoma v. EPA,
134 S. Ct. 2662 (2014) 2

Pabst Brewing Co. v. Corrao,
161 F.3d 434 (7th Cir. 1998) 23, 24

Parillo v. FKI Indus., Inc.,
608 F. Supp. 2d 264 (D. Conn. 2009) 24

Policy v. Powell Pressed Steel Co.,
770 F.2d 609 (6th Cir. 1985) 13

Reese v. CNH Am. LLC,
574 F.3d 315 (6th Cir. 2009) ..... *passim*

Rossetto v. Pabst Brewing Co.,
217 F.3d 539 (7th Cir. 2000) ..... *passim*

Ryan v. Chromalloy Am. Corp.,
877 F.2d 598 (7th Cir. 1989) 23, 24

Schreiber v. Philips Display Components Co.,
580 F.3d 355 (6th Cir. 2009) 14

Senn v. United Dominion Indus., Inc.,
951 F.2d 806 (7th Cir. 1992) 23, 24

Smith v. ABS Indus., Inc.,
890 F.2d 841 (6th Cir. 1989) 13

Sprague v. General Motors Corp.,
133 F.3d 388 (6th Cir. 1998) 5, 16

Struble v. N.J. Brewery Employees' Welfare Trust Fund,
732 F.2d 325 (3d Cir. 1984) 21, 24

Tackett v. M&G Polymers USA, LLC,
561 F.3d 478 (6th Cir. 2009) 10, 15, 34

Tackett v. M&G Polymers USA, LLC,
733 F.3d 589 (6th Cir. 2013) ..... *passim*

Temme v. Bemis Co.,
622 F.3d 730 (7th Cir. 2010) 23, 24

Textile Workers Union v. Lincoln Mills,
353 U.S. 448 (1957) 8

UAW v. Gen. Motors Corp.,
No. 05-CV-73991-DT, 2006 WL
891151 (E.D. Mich. Mar. 31, 2006) 27, 29

UFCWU v. PPG Indus., Inc.,
No. 2:01CV1751, 2006 WL 895087
(W.D. Pa. Mar. 31, 2006) 24

UMW v. Am. Commercial Lines Transp. Serv., LLC,
No. 4:08CV1777SNLJ, 2010 WL
4941346 (E.D. Mo. Nov. 30, 2010) 18

UMW v. Brushy Creek Coal Co.,
505 F.3d 764 (7th Cir. 2007) 23, 24

In re Unisys Corp. Retiree Med. Ben. ERISA Litig.,
58 F.3d 896 (3d Cir. 1995) 7, 21

USW v. PPG Indus., Inc.,
No. 2:01CV1601, 2006 WL 895090
(W.D. Pa. Mar. 31, 2006) 24

Wallitsch v. Corona Corp.,
No. CIV. A. 87-2239, 1988 WL 30037
(E.D. Pa. Sept. 29, 1988) 24

Webb v. GAF Corp.,
936 F. Supp. 1109 (N.D.N.Y. 1996) 24

Weimer v. Kurz-Kasch, Inc.,
773 F.2d 669 (6th Cir. 1984) 13

Williams v. Wellman Thermal Sys. Corp.,
684 F. Supp. 584 (S.D. Ind. 1988) 24

Winnett v. Caterpillar, Inc.,
579 F. Supp. 2d 1008 (M.D. Tenn. 2008) 18

Wise v. El Paso Natural Gas Co.,
986 F.2d 929 (5th Cir. 1993) 16, 26

Witmer v. Acument Global Tech., Inc.,
694 F.3d 774 (6th Cir. 2012) 14

Wood v. Detroit Diesel Corp.,
607 F.3d 427 (6th Cir. 2010) 14

Yates v. United States,
134 S. Ct. 1935 (2014) 2

Yolton v. El Paso Tenn. Pipeline Co.,
435 F.3d 571 (6th Cir. 2006) 14, 30

Yolton v. El Paso Tenn. Pipeline Co.,
668 F. Supp. 2d 1023 (E.D. Mich. 2009) 18

Zielinski v. Pabst Brewing Co.,
463 F.3d 615 (7th Cir. 2006) 23, 24

Statutes and Rules

Employee Retirement Income Security Act of 1974 ("ERISA") § 3, 29 U.S.C. § 1002 (2012) 6

ERISA § 201, 29 U.S.C. § 1051 (2012) 6

ERISA § 203, 29 U.S.C. § 1053 (2012) 6

ERISA § 302, 29 U.S.C. § 1082 (2012) 7

ERISA § 502, 29 U.S.C. § 1132 (2012) 34

Labor Management Relations Act § 301, 29 U.S.C. § 185 (2012) 34

S. Ct. R. 37 1

Legislative Materials

S. Rep. No. 93-383 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4890 7

Other Authorities

Affidavit of Ronald Kolka, *In re Chrysler LLC*, Case 09-50002-smb (Bankr. S.D.N.Y. Apr. 30, 2009) 31

Nathan Bomey & Alisa Priddle, *Dillon: Retiree Health Care, Not Pension Shortfall, a Core Reason for Detroit Bankruptcy*, Detroit Free Press, Nov. 5. 2013 32

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FASB, Summary of Statement No. 106 (Dec. 1990) 26

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Transcript of Trial, *In re City of Detroit, MI*, Case 13-53846-swr (Bankr. E.D. Mich. Nov. 8, 2013) 32

INTERESTS OF *AMICUS CURIAE*[1]

The National Association of Manufacturers ("NAM") is the largest association of manufacturers in the United States. Its membership comprises small and large manufacturers in every industrial sector and in all fifty states. The manufacturing industry employs nearly twelve million men and women, contributes more than $1.8 trillion annually to the American economy, has the largest economic impact of any major sector, and accounts for two-thirds of private sector research and development. NAM is the leading advocate for a policy agenda that helps manufacturers compete in the global economy and create jobs throughout the United States.

Because cases before this Court are often important to its members, NAM regularly participates as an *amicus* before this Court. In the just-completed Term, NAM filed six *amicus* briefs on the merits,[2] and five *amicus* briefs at the petition stage.[3]

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[1] On June 20, 2014, NAM informed counsel of record for all parties of its intent to file this brief. *See* S. Ct. R. 37.3(a). Petitioners have filed a letter with the Court consenting to *amicus curiae* briefs in this matter. A consent letter from Respondents accompanies this brief. No counsel for a party authored this brief in whole or in part; no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief; and no person other than NAM, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. *See id.* R. 37.6.

[2] *Halliburton v. Erica P. John Fund, Inc.*, 134 S. Ct. 2398 (2014); *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014); *CTS Corp. v. Waldburger*, 134 S. Ct. 2175 (2014); *Argentina v. NML Capital, Ltd.*, 134 S. Ct. 2250 (2014); *Integrity*

The issue in this case is of immense importance to NAM's members and to the American manufacturing industry as a whole. Many of NAM's members engage in collective bargaining with union representatives, and the resulting agreements often provide health benefits for retired workers. A determination that retiree health benefits are vested can impose an obligation on the employer for decades with an aggregate cost to the employer of millions or even billions of dollars. (*See* Part II below.)

Even though Congress made a careful and explicit decision when it passed the Employee Retirement Income Security Act ("ERISA") in 1974 that welfare benefits would not be mandatorily vested, manufacturers who have operations or sell products nationwide are currently subject to conflicting standards for determining whether retiree health benefits are unalterable for the life of all retirees. *See Rossetto v. Pabst Brewing Co.*, 217 F.3d 539, 543 (7th Cir. 2000) ("Cases in [the] circuits are all over the lot."). Because different circuits draw different conclusions from the same collective bargaining language, litigation on this issue is common. Representatives on both sides of the collective bargaining table simply do not know, after long and hard negotiations, what the employers' obligations to retirees will be. These con-

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Staffing Solutions, Inc. v. Busk, 134 S. Ct. 1490 (2014); *Yates v. United States*, 134 S. Ct. 1935 (2014).

[3] *Accenture, L.L.P. v. Wellogix, Inc.*, 134 S. Ct. 2725 (2014); *GenOn Power Midwest, L.P. v. Bell*, 134 S. Ct. 2696 (2014); *Oklahoma v. EPA*, 134 S. Ct. 2662 (2014); *North Dakota v. EPA*, 134 S. Ct. 2662 (2014); *Exxon Mobil Corp. v. City of New York*, 134 S. Ct. 1877 (2014).

flicting standards often lead to venue fights to determine which circuit's law will resolve the issue of vesting. (*See* Part III.B. below.)

A clear rule applicable nationwide is in the interest of manufacturers and all other employers, as well as unions, retirees, and the judicial system. Accordingly, NAM submits this brief in support of Petitioners.

SUMMARY OF ARGUMENT

Four decades ago, Congress made a careful and conscious decision not to mandate vesting of welfare benefits, including retiree health care benefits. Twice, this Court has unanimously acknowledged and paid deference to that congressional decision. The Sixth Circuit's *Yard-Man* inference,[4] and the canons of contract construction that have grown up around it, flout this congressional decision by creating a strong inference that collectively-bargained retiree health benefits *are* vested. More in accord with the congressional intent is the Third Circuit's rule that a union or retiree must show "clear and express language" in the collective bargaining agreement to demonstrate vesting.

This issue is of major consequence to manufacturers and other employers throughout the United States. Health benefits for retirees potentially impose hundreds of billions of dollars of liabilities on the Nation's employers. An inference of vesting could render those benefits unalterable, notwithstanding dramatic

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[4] *Int'l Union, UAW v. Yard-Man, Inc.*, 716 F.2d 1476, 1482 (6th Cir. 1983).

changes in the law, technology, delivery, and cost of health care.

Moreover, the Sixth Circuit rule strongly inferring vesting has created an incentive for unions to avoid bargaining about whether benefits are vested. Even if unions do negotiate about retiree benefits, the *Yard-Man* inference allows retirees to undermine any collectively-bargained limitations on the benefits by claiming the benefits were vested, and thus unalterable even pursuant to collective bargaining. Thus the *Yard-Man* inference removes an issue of increasing importance from the bargaining table. Faced with a strong inference of vesting and union unwillingness to negotiate, or the threat that retirees can void even negotiated limits on their health benefits, too many employers have been forced into bankruptcy court. (*See* Part II.C. below.)

A clear and express language rule would address these issues. It would allow bargainers to know during negotiation what is necessary to create vesting, and would provide clear notice after execution of the agreement whether benefits are in fact vested. Judicial resolution of vesting issues would be simplified with far less need for venue fights and trials of disputed facts. Of greater importance, a clear and express language rule would fulfill rather than frustrate the congressional intent.

ARGUMENT

I. THE "CLEAR AND EXPRESS LANGUAGE" RULE FOR JUDGING WHETHER RETIREE HEALTH BENEFITS ARE VESTED WOULD SERVE THE CONGRESSIONAL INTENT AND PROMOTE GREATER CERTAINTY FOR EMPLOYERS, UNIONS, AND RETIREES.

"[T]o vest benefits is to render them forever unalterable." *Int'l Union, UAW v. Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999).[5] When a court deems retiree health benefits vested, the employer must continue paying medical benefits for the life of each retiree. In light of the ever-increasing cost of medical care, the number of retirees that may benefit, and the life expectancy of each retiree, the cost to a company of such a vesting decision can be millions or even billions of dollars. (*See* Part II below.) Thus, the vesting issue is of critical importance to employers, unions, and retirees.

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[5] *See also Sprague v. General Motors Corp.*, 133 F.3d 388, 400 (6th Cir. 1998) (en banc) (same); *Tackett v. M&G Polymers USA, LLC*, 733 F.3d 589, 596 (6th Cir. 2013) (*Tackett II*) (Pet. App. 11) ("To vest, in this context, means to remain binding beyond the expiration of the collective bargaining agreement." (internal quotation marks omitted)); *Yard-Man*, 716 F.2d at 1480 ("nonterminating lifelong insurance benefits").

A. Congress Made a Conscious Decision Not To Mandate Vesting of Welfare Benefits, Including Retiree Health Care Benefits.

When it passed ERISA in 1974, Congress made a careful, conscious, and clear policy decision to mandate vesting of pension benefits. ERISA § 203, 29 U.S.C. § 1053 (2012) (mandating that pension benefits are vested). In contrast, Congress made an equally careful, conscious, and clear decision *not* to mandate vesting of welfare benefits, including retiree health care benefits. ERISA § 201(1), 29 U.S.C. § 1051(1) (2012) (not vesting welfare benefits). ERISA deems health benefits to be welfare, not pension, benefits. ERISA § 3(1), 29 U.S.C. § 1002(1) (2012) (defining welfare benefit plan). This Court has unanimously recognized that "ERISA . . . specifically exempts 'employee welfare benefit plan[s]' from its stringent vesting requirements." *Inter-Modal Rail Emps. Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 514 (1997). Again unanimously, the Court confirmed that "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans. Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (citation omitted).

This congressional decision not to mandate vesting of welfare benefits was well-reasoned. Pension benefits are normally payable in readily predictable cash installments. ERISA requires employers who

sponsor defined benefit pension plans to set aside funds for those plans. ERISA § 302, 29 U.S.C. § 1082 (2012). Welfare benefits are subject to no such funding requirement. The cost of health benefits in particular depends on the vagaries of changes in the law, advances in available treatments, escalating medical and prescription drug costs, and of course the health and lifespans of the individual beneficiaries.[6] Congress understood that mandatory vesting of health benefits "would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income." S. Rep. No. 93-383, at 51 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4890, 4935. Likewise, courts have recognized that " '[a]utomatic vesting was rejected [by Congress] because the costs of such plans are subject to fluctuating and unpredictable variables. . . . These unstable variables prevent accurate prediction of future needs and costs.' " *In re Unisys Corp. Retiree Med. Ben. ERISA Litig.*, 58 F.3d 896, 901 (3d Cir. 1995) (quoting *Moore v. Metro. Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988)).

For retiree health benefits to vest and continue for the retiree's life beyond the duration of the collec-

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[6] "The value of a pension benefit, whether defined or undefined, is clear cut—a matter of concrete dollars and cents, fairly measurable as a matter of principal or income stream before retirement, at retirement or after retirement. Vested health-care benefits are another matter. Employers do not send their active or retired employees a monthly account itemizing the value of their health-care benefits. And with good reason: What would it say? What could it say?" *Reese v. CNH Am. LLC*, 574 F.3d 315, 324 (6th Cir. 2009).

tive bargaining agreement ("CBA"), the employer and the union must agree that the benefits will vest. *See Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 261 (6th Cir. 2012) ("[V]esting of retiree welfare benefits is a matter of contractual agreement."). Without such an agreement to vest, promises in a collective bargaining agreement terminate when the agreement terminates. As this Court explained in *Litton Financial Printing Division v. NLRB*:

> [C]ontractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement. Exceptions are determined by contract interpretation. Rights which accrued or vested under the agreement will, as a general rule, survive termination of the agreement. And of course, if a collective-bargaining agreement provides *in explicit terms* that certain benefits continue after the agreement's expiration, disputes as to such continuing benefits may be found to arise under the agreement, and so become subject to the contract's arbitration provisions.

501 U.S. 190, 207–08 (1991) (emphasis added).

Collective bargaining agreements must be interpreted in accordance with federal labor law as supplemented by traditional rules of contract interpretation. *See Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 456–57 (1957). The lower courts uniformly express allegiance to this principle, but have employed diametrically opposing rules of construction—and reached dramatically different results—in de-

termining whether retiree health benefits are vested. *Compare Skinner*, 188 F.3d at 138–39 ("Although construction of collective bargaining agreements is generally governed by federal law, traditional rules of contract construction apply when not inconsistent with federal labor law"; holding that retiree health benefits vest only if supported by "clear and express language of an agreement to vest"), *with Yard-Man*, 716 F.2d at 1479, 1482 ("traditional rules for contractual interpretation are applied as long as their application is consistent with federal labor policies"; creating an "inference" that because retiree health benefits are a permissive subject of bargaining and are a "status benefit," they should continue for as long as the individual holds the status of retiree, i.e., for life).

The issue in this case, therefore, is whether the Sixth Circuit's judicially-created canons of contractual construction for determining vesting of retiree health benefits are faithful to the congressional decision that such benefits do not vest by operation of law.

B. The *Yard-Man* Inference Used by the Court Below Frustrates the Congressional Intent and the Expectations of Bargainers.

1. The *Yard-Man* Inference and Its Corollary Rules of Construction Foreclose Argument on Vesting.

In its two decisions in the current case, the Sixth Circuit relied heavily on *Yard-Man*.[7] Thus, the *Yard-Man* inference and its corollary canons of construction are at the center of this case.

In *Yard-Man*, the Sixth Circuit deemed "ambiguous" language in the CBA stating that "[t]he Company will provide insurance benefits equal to the active group benefits . . . for the former employee and his spouse." 716 F.2d at 1480.[8] Although the Sixth Cir-

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[7] In the first appeal to the Sixth Circuit, the court was clear that it was applying the *Yard-Man* analysis. *See Tackett v. M&G Polymers USA, LLC*, 561 F.3d 478, 481 (6th Cir. 2009) (*Tackett I*) (Pet. App. 89–90 ("In resolving this appeal, we must decide . . . whether, under this Circuit's *Yard-Man* analysis . . . the Plaintiffs have sufficiently established a right to vested health-care benefits to survive a motion to dismiss"); *id.* at 489–90 (Pet. App. 109–13) (applying *Yard-Man* analysis). On the second appeal, the Sixth Circuit quoted its earlier discussion of *Yard-Man*, and explained: "*Tackett I* interpreted the quoted language of the CBA, standing alone, as indicating an intent to vest and this interpretation bound the district court." *Tackett II*, 733 F.3d at 596–97, 599 (Pet. App. 11–13, 19).

[8] The court dismissed the durational clause in the CBA as insufficient to defeat vesting because the "clause does not specifically refer to the duration of benefits." *Yard-Man*, 716 F.2d at 1482.

cuit correctly observed that no "federal labor policy identified to this Court presumptively favor[s] the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent," *id.* at 1482, the court ignored the congressional directive that welfare benefits do not mandatorily vest.

Instead, the Sixth Circuit constructed a framework directly at odds with the congressional directive. The court invoked "traditional rules for contractual interpretation" for addressing the vesting issue, *id.* at 1479, but supplemented those standard rules with two additional inferences. *First*, the court correctly noted that retiree benefits are "permissive not mandatory subjects of collective bargaining," but then inferred vesting because "it is unlikely that such benefits, which are typically understood as a form of delayed compensation or reward for past services, would be left to the contingencies of future negotiations." *Id.* at 1482. Thus, it reasoned, "the finding of an intent to create interminable rights to retiree insurance benefits in the absence of explicit language is not, in any discernible way, inconsistent with federal labor law." *Id.*

Next, it created an inference based on the status of beneficiaries and retirees:

> [R]etiree benefits are in a sense "status" benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained. Thus, when the parties contract for benefits which accrue upon achievement of retiree status, *there is an inference that*

> *the parties likely intended those benefits to continue as long as the beneficiary remains a retiree.*

Id. (emphasis added). The court provided no authority for either of these inferences, nor did it address, much less reconcile those inferences with, the decision by Congress *not* to mandate vesting of welfare benefits.

In the three decades since it decided *Yard-Man*, the Sixth Circuit has developed numerous corollaries to supplement the two *Yard-Man* inferences discussed above. It now holds that when CBAs use eligibility for pension benefits, which are vested, as the basis for determining eligibility for retiree health benefits, an inference arises that the health benefits are vested as well. *See, e.g., Tackett II*, 733 F.3d at 597 (Pet. App. 13–15); *Golden v. Kelsey-Hayes Co. (In re Golden)*, 73 F.3d 648, 656 (6th Cir. 1996). Because CBAs commonly use the same tests for retiree health care eligibility as for pension eligibility, the "tying" analysis has become almost a per se rule of vesting that is directly contrary to congressional intent.

Moreover, the Sixth Circuit has relied on the presence of durational limits on other benefits, contrasted with the absence of durational limits specifically applicable to retiree health benefits, as a basis to infer that health benefits were subject to no durational limit and thus are vested. *Yard-Man*, 716 F.2d at 1481–82 (durational limit on savings and pension plan programs); *see also Moore v. Menasha Corp.*, 690 F.3d 444, 458 (6th Cir. 2012) ("The Sixth Circuit has consistently held that the inclusion of specific dura-

tional limitations in some provisions, but not others, suggests that benefits not so specifically limited, were intended to survive." (internal quotation marks omitted)).

It has relied on the provision of a Medicare supplement to retirees eligible for Medicare, coupled with the fact that not all current retirees will reach Medicare eligibility during the term of the existing CBA, as a basis for finding that retiree health benefits were intended to last beyond the existing CBA. Otherwise, it reasons, the promise of a Medicare supplement is "illusory" to those retirees not yet eligible for it. *See, e.g.*, *Maurer v. Joy Techs., Inc.*, 212 F.3d 907, 918 (6th Cir. 2000).

And it has found an intent to vest when an employer fails to terminate retiree health benefits immediately upon expiration of the CBA or during a strike. *See Int'l Union, UAW v. Cadillac Malleable Iron Co.*, 728 F.2d 807, 808–09 (6th Cir. 1984); *accord Weimer v. Kurz-Kasch, Inc.*, 773 F.2d 669, 676 n.6 (6th Cir. 1984). Often, the Sixth Circuit combines several of these corollary inferences in a single case to find vesting.

The results speak for themselves. Since *Yard-Man*, the Sixth Circuit has addressed whether retiree health benefits were vested in twenty-one published decisions, and has held the benefits vested in all but two.[9] In effect, employers can escape vesting only by

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[9] Decisions holding benefits vested are: *Yard-Man*, 716 F.2d at 1476; *Cadillac Malleable*, 728 F.2d at 807; *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609 (6th Cir. 1985); *Weimer*, 773 F.2d at 669; *Smith v. ABS Indus., Inc.*, 890 F.2d 841 (6th

showing a clear statement in the CBA—specifically tailored to health benefits—that unambiguously precludes vesting. *See Noe*, 520 F.3d at 565 (Sutton, J., concurring in part and dissenting in part). Thus, the *Yard-Man* rule has turned the congressional decision *not* to mandate vesting of welfare benefits on its head. In the absence of unambiguous language in the CBA negating vesting, *any retiree* can claim an inference of vested health benefits merely by observing that retiree health benefits are a permissive subject of bargaining. And, in the absence of unambiguous language in the CBA negating vesting, *any retiree* can claim the "status benefit" inference merely by being a retiree.[10]

Cir. 1989); *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991); *Golden*, 73 F.3d at 648; *Int'l Union, UAW v. BVR Liquidating, Inc.*, 190 F.3d 768 (6th Cir. 1999); *Maurer*, 212 F.3d at 907; *McCoy v. Meridian Auto. Sys., Inc.*, 390 F.3d 417 (6th Cir. 2004); *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006); *Noe v. PolyOne Corp.*, 520 F.3d 548 (6th Cir. 2008); *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064 (6th Cir. 2008); *Schreiber v. Philips Display Components Co.*, 580 F.3d 355 (6th Cir. 2009); *Reese*, 574 F.3d at 315; *Wood v. Detroit Diesel Corp.*, 607 F.3d 427 (6th Cir. 2010); *Moore*, 690 F.3d at 444; *Bender*, 681 F.3d at 253; *Tackett II*, 733 F.3d at 589 (Pet. App. 1). The two exceptions are *Bittinger v. Tecumseh Prods. Co.*, 123 F.3d 877 (6th Cir. 1997) (adopting district court opinion), and *Witmer v. Acument Global Tech., Inc.*, 694 F.3d 774 (6th Cir. 2012).

[10] The Sixth Circuit has attempted to disclaim any "legal presumption" in the *Yard-Man* rule. *See Cadillac Malleable*, 728 F.2d at 808. It has asserted that "*Yard-Man* does not shift the burden of proof to the employer, nor does it require specific anti-vesting language before a court can find that the parties did not intend benefits to vest." *Golden*, 73 F.3d at 656. But the Sixth Circuit is not of uniform mind in describing *Yard-Man*, leading at least one judge to describe it once as a "presumption" and

This case illustrates the heavy if not outcome determinative tilt of Sixth Circuit precedent on vesting. In the first appeal from dismissal of the complaint, the Sixth Circuit applied the *Yard-Man* framework. It began by espousing its use of "[g]eneral principles of contract interpretation," *Tackett I*, 561 F.3d at 489 (Pet. App. 109), but then quickly moved to the inferences described above. "Language in a collective bargaining agreement," it wrote, "that equat(es) eligibility for retiree health benefits with eligibility for a pension suggests an intent to vest." *Id.* (Pet. App. 110) (internal quotation marks omitted). It noted that "it is unlikely that [retiree health benefits] would be left to the contingencies of future negotiations." *Id.* (Pet. App. 110) (internal quotation marks omitted). "[W]e find it unlikely," it further reasoned, that the union would agree to "a full Company contribution" "if the company could unilaterally change the level of contribution." *Id.* at 490 (Pet. App. 112).

On remand, the district court ruled that the benefits were vested, and on the second appeal the Sixth Circuit affirmed. It noted that the CBA language promising "a full Company contribution" "standing alone [indicated] an intent to vest and this interpretation bound the district court," and the "linkage of health care benefits to pension benefits" also supported the conclusion. *Tackett II*, 733 F.3d at 600 (Pet. App. 19–20).

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later as "nothing more than a nudge in favor of vesting in close cases." *Compare Noe*, 520 F.3d at 568 (Sutton, J., concurring in part and dissenting in part) ("an omnipresent presumption [that] appears to have become a clear-statement rule"), *with Reese*, 574 F.3d at 321 (Sutton, J.) ("nudge").

2. The *Yard-Man* Inference and Its Corollaries Are Not Well-Reasoned.

For several reasons, the *Yard-Man* inference and its corollaries are not well-reasoned. *First*, the inference and corollaries apply only to collectively-bargained retiree benefits. In contrast, for retiree health benefits that are not collectively-bargained, the Sixth Circuit defers to the congressional policy rejecting mandatory vesting. In *Sprague*, a class of retirees previously employed as salaried workers alleged that their health benefits were vested. The court rejected that argument, explaining: "Because vesting of welfare plan benefits is not required by law, an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest 'must be found in the plan documents and *must be stated in clear and express language.*'" 133 F.3d at 400 (emphasis added) (quoting *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 937 (5th Cir. 1993)).

Although the *Yard-Man* rule applies only to collectively-bargained benefits,[11] the Sixth Circuit has pointed to nothing in the Labor Management Relations Act ("LMRA") that overrides the strong mandate in ERISA against inferring vesting. Indeed, as shown, the LMRA requires use of rules of contract construction that are *consistent with federal labor policy*, but the *Yard-Man* rule conflicts directly with the express policy of Congress in ERISA not to mandate vesting of welfare benefits.

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[11] *BVR Liquidating*, 190 F.3d at 772–73.

Moreover, if an inference of vesting were justified—and ERISA makes clear it is not—the Sixth Circuit rule is exactly backwards. It would be more appropriate to apply such an inference to assist an individual who lacked protection of a union, and to assume the union member was adequately represented during negotiations. *See Rosetto*, 217 F.3d at 543–44 (Posner, J.) ("[R]eversal of [the Sixth Circuit's presumptions would make better sense."); *Noe*, 520 F.3d at 568–69 (Sutton, J., concurring in part and dissenting in part) ("One might have thought we would apply the same rule in both settings or, if we were to put a thumb on just one of the scales, we would do so only where the employee did not have the benefit of a union negotiating the contract.").

Second, the assumption that an inference of vesting is justified because retiree welfare benefits are a permissive subject of bargaining is both illogical and overbroad. The Sixth Circuit asserted in *Yard-Man* that it is "unlikely" employees would leave their retirement benefits "to the contingencies of future negotiations." 716 F.2d at 1482. With such a strong incentive to negotiate for vested benefits in the CBA, however, it is more logical to assume that the *absence* of explicit vesting language means the retirees *failed* to obtain a commitment to vest. It simply makes no sense to infer that a term the union and its members ardently wanted is implicit in the CBA by its silence. Further, the inference is far too broad because retiree benefits are always, as a matter of law, a permissive subject of bargaining. As a result, this inference will be present with regard to every CBA, regardless of the bargaining history and regardless of whether the

union actually gave anything in exchange for vested benefits.

The Sixth Circuit's reliance on the limits of permissive bargaining is also unpersuasive. Although it is true that unions have no statutory duty to represent existing retirees, unions *do* have a duty to represent employees *before* retirement, and thus have ample opportunity to obtain prospective vesting language. Moreover, unions are not precluded from negotiating for retirees, and in fact do so regularly, often obtaining increased benefits for retirees even though such increased benefits may require the unions to compromise benefits payable to current workers.[12]

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[12] In *Allied Chemical & Alkali Workers of America v. Pittsburgh Plate Glass Co.*, the Court recognized that a union has "no statutory duty" to represent retirees, but that "nothing we hold today precludes permissive bargaining over the benefits of already retired employees." 404 U.S. 157, 171 n.11, 181 n.20 (1971). Although the Court acknowledged that unions might, on occasion, "favor[] active employees at the expense of retirees' benefits," *id.* at 173, unions have in fact often negotiated for enhanced benefits for their retirees. *See, e.g.*, *UMW v. Am. Commercial Lines Transp. Serv., LLC*, No. 4:08CV1777SNLJ, 2010 WL 4941346, at *23 (E.D. Mo. Nov. 30, 2010) ("Again, the Retiree Plaintiffs have all conceded that the UMWA has the authority to negotiate health benefits on their behalf, and has done so in the past."); *Yolton v. El Paso Tenn. Pipeline Co.*, 668 F. Supp. 2d 1023, 1026 (E.D. Mich. 2009) (finding "a pattern and practice of the UAW representing retirees in connection with their health care benefits and negotiating agreements that protect or improve those benefits"); *Winnett v. Caterpillar, Inc.*, 579 F. Supp. 2d 1008, 1013–15 (M.D. Tenn. 2008) ("UAW could and did negotiate increases to the pension and medical benefits offered to current retirees."). Moreover, as shown (Part II.B. below) unions have also negotiated court-approved settlements

Nor does the inference that benefits vest merely because of retiree status withstand examination. *Every* retiree formerly represented by a union can claim this inference, regardless of what may have happened in the collective bargaining negotiations. The inference would apply even if the union made an explicit demand for vested benefits and relented when the employer refused. Moreover, like the permissive bargaining inference, this universally applicable inference directly contradicts the express congressional policy rejecting mandatory vesting of welfare benefits.

In short, not only does the *Yard-Man* inference offend the conscious decision by Congress that welfare benefits are not automatically vested, each component of the inference lacks support in precedent or logic.

C. A Rule Requiring "Clear and Express Language" in the CBA for Vesting of Retiree Health Benefits Best Effectuates Congressional Intent.

In resolving claims that collectively-bargained retiree health benefits are lifetime vested and unalterable, the rule that best accommodates congressional intent and the expectations of the parties is that vesting must be shown by clear and express language in the collective bargaining agreement. This was the conclusion of the Court of Appeals for the Third Circuit in *Skinner*, 188 F.3d at 139.

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with major manufacturers on behalf of retirees regarding their health benefits.

The Third Circuit considered whether language in the CBAs promising that the employer "will continue to provide Blue Cross-Blue Shield hospitalization and surgical coverage, all costs being borne by the Company," and "will continue to provide . . . prescription drug insurance policy with deductible . . . all costs being borne by the Company," created an unalterable entitlement to fully-paid benefits for the rest of the retirees' lives. *Id.* at 135. Unlike the Sixth Circuit in *Yard-Man*, the Third Circuit carefully reviewed the provisions of ERISA that declare welfare benefits not vested, the legislative history of that decision, and the federal policies regarding interpretation of collective bargaining agreements. *Id.* at 137–39. Based on this review, the court rejected the claim for vested benefits, reasoning: "Because vesting of welfare plan benefits constitutes an extra-ERISA commitment, an employer's commitment to vest such benefits is not to be inferred lightly and *must be stated in clear and express language.*" *Id.* at 139 (emphasis added). This result is in accord with the Sixth Circuit's decision in *Sprague*, which addressed retiree benefits that were *not* collectively-bargained.

The court also reviewed decisions of other circuits, including the Sixth Circuit, addressing the vesting issue. It found the Sixth Circuit's *Yard-Man* inference unpersuasive. It rejected *Yard-Man*'s reasoning that because retiree health benefits are permissive subjects of bargaining, courts should assume vesting: "[T]hose who fear that their unions will not bargain for continued benefits for retirees need only see to it that specific vesting language protecting those benefits is incorporated into collective bargaining agreements." 188 F.3d at 141.

The Third Circuit also rejected *Yard-Man*'s denomination of retiree health benefits as "status benefits," which should be assumed to continue for as long as the retiree remained retired from the company (that is, for life). To begin, the *Skinner* court agreed with the Eighth Circuit that it is " 'illogical to infer an intent to vest welfare benefits in every situation where an employee is eligible to receive them on the day he retires.' " *Id.* at 141–42 (quoting *Anderson v. Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988)). Further, it reasoned that "the *Yard-Man* inference may be contrary to Congress' intent in choosing specifically not to provide for the vesting of employee welfare benefits." *Id.* at 142.

In addition to fulfilling the congressional intent in ERISA, the *Skinner* rule also provides greater certainty to bargainers and allows expeditious and efficient adjudication of disputes. Bargainers on each side of the table will know what language is necessary to achieve vesting. They will also have confidence that courts will not use inferences to override intended limits on the benefits. Moreover, the face of the CBA will indicate whether or not benefits are vested without the need for extensive discovery or protracted judicial proceedings. Indeed, the clarity of the *Skinner* rule will obviate most vesting disputes altogether.[13]

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[13] The Third Circuit has held benefits vested in no published cases. It held them not vested in four cases. *Struble v. N.J. Brewery Employees' Welfare Trust Fund*, 732 F.2d 325, 331 (3d Cir. 1984); *Unisys*, 58 F.3d at 896; *Skinner*, 188 F.3d at 130; *Int'l Chem. Workers Union v. PPG Indus., Inc.*, 236 F. App'x 789 (3d Cir. 2007).

D. The Second and Seventh Circuit Approaches Provide Insufficient Certainty and May Lead to Extensive Litigation.

The Second and Seventh Circuits have taken a middle ground in addressing the vesting issue. The Second Circuit has proclaimed that "[w]e will not infer a binding obligation to vest benefits absent some language that itself reasonably supports that interpretation." *Joyce v. Curtis-Wright Corp.*, 171 F.3d 130, 133–35 (2d Cir. 1999) (deeming language stating that insurance "will be provided for employees receiving or becoming entitled to receive pension payments" insufficient to create vesting or prove an ambiguity). Likewise, the Seventh Circuit "established a presumption that an employee's entitlement to [health benefits] expires with the agreement creating the entitlement, rather than vesting, but the presumption can be knocked out by a showing of genuine ambiguity, either patent or latent, beyond silence." *Rossetto*, 217 F.3d at 543.

Although on their face these standards are more consistent with the congressional policy of not mandating vesting, they are less faithful to that policy and provide less certainty than the "clear and express language" standard used in *Skinner*.[14] Like the

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[14] The Second Circuit has held benefits vested in no cases and not vested in three cases. *Am. Federation of Grain Millers v. Int'l Multifoods Corp.*, 116 F.3d 976 (2d Cir. 1997); *Joyce*, 171 F.3d at 130; *Baldwin v. Motor Components, L.L.C.*, 155 F. App'x 16 (2d Cir. 2005). The Seventh Circuit has held benefits vested in five cases. *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993); *Diehl v. Twin Disc, Inc.*, 102 F.3d 301 (7th Cir.

"clear and express language" standard, the Second and Seventh Circuit standards do not allow silence to lead to an inference of vesting. Unlike the Third Circuit standard, however, they permit retirees to argue that anything less than clear language addressing vesting creates an ambiguity, thus allowing introduction of extrinsic evidence on the vesting issue. Predictably, they have led to numerous disputes about whether the collective bargaining agreement is ambiguous, and sometimes have required jury trials to resolve the vesting issue.[15] Of twenty-eight cases addressing vesting in the Second and Seventh Circuits, seven have proceeded to trial to resolve purported

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1996); *Rossetto*, 217 F.3d at 539; *Zielinski v. Pabst Brewing Co.*, 463 F.3d 615 (7th Cir. 2006); *Temme v. Bemis Co.*, 622 F.3d 730 (7th Cir. 2010). It has held benefits not vested in eight cases. *Ryan v. Chromalloy Am. Corp.*, 877 F.2d 598 (7th Cir. 1989); *Senn v. United Dominion Indus., Inc.*, 951 F.2d 806 (7th Cir. 1992); *Murphy v. Keystone Steel & Wire Co.*, 61 F.3d 560 (7th Cir. 1995); *Pabst Brewing Co. v. Corrao*, 161 F.3d 434 (7th Cir. 1998); *Int'l Union, UAW v. Rockford Powertrain, Inc.*, 350 F.3d 698 (7th Cir. 2003); *Cherry v. Auburn Gear, Inc.*, 441 F.3d 476 (7th Cir. 2006); *Barnett v. Ameren Corp.*, 436 F.3d 830 (7th Cir. 2006); *UMW v. Brushy Creek Coal Co.*, 505 F.3d 764 (7th Cir. 2007).

[15] The circuits appear to be split on whether factual disputes regarding vesting require a jury trial. The Sixth Circuit holds a jury is not appropriate, *see Reese*, 574 F.3d at 327–28, whereas the Second and Seventh Circuits appear to allow a jury trial, *see Joyce*, 171 F.3d at 133 (trial court held jury trial); *Senn*, 951 F.2d at 813–15 (affirming district court's grant of jury trial on issue of vesting).

ambiguities,[16] compared to none out of seven in the Third Circuit.[17]

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[16] In the Second Circuit, one case proceeded to trial to determine vesting. *Webb v. GAF Corp.*, 936 F. Supp. 1109 (N.D.N.Y. 1996). In six cases, the Second Circuit or its district courts determined vesting without trial. *Int'l Multifoods*, 116 F.3d at 976; *Joyce*, 171 F.3d at 130; *Baldwin*, 155 F. App'x at 16; *Parillo v. FKI Indus., Inc.*, 608 F. Supp. 2d 264 (D. Conn. 2009); *Enright v. N.Y .City Dist. Council of Carpenters Welfare Fund*, No. 12 CIV. 4181 JPO, 2013 WL 3481358 (S.D.N.Y. July 10, 2013); *Conn. Indep. Util. Workers Local 12924 v. Conn. Nat. Gas Corp.*, No. 3:12CV961 JBA, 2014 WL 941805 (D. Conn. Mar. 11, 2014). In the Seventh Circuit, six cases proceeded to trial to determine vesting. *Senn*, 951 F.2d at 806; *Bidlack*, 993 F.2d at 603; *Rossetto*, 217 F.3d at 539; *Williams v. Wellman Thermal Sys. Corp.*, 684 F. Supp. 584 (S.D. Ind. 1988); *Bialoszynski v. Milwaukee Forge*, 419 F. Supp. 2d 1045 (E.D. Wis. 2006); *Oakley v. Remy Int'l, Inc.*, 795 F. Supp. 2d 810 (S.D. Ind. 2011). Fifteen cases determined vesting without trial. *Ryan*, 877 F.2d at 598; *Murphy*, 61 F.3d at 560; *Diehl*, 102 F.3d at 301; *Corrao*, 161 F.3d; *Rockford Powertrain*, 350 F.3d at 698; *Zielinski*, 463 F.3d at615; *Cherry*, 441 F.3d at 476; *Barnett*, 436 F.3d at 830; *Brushy Creek Coal*, 505 F.3d at 764; *Temme*, 622 F.3d at 730; *Leahy v. Page Eng'g Co.*, No. 89 C 9577, 1992 WL 51710 (N.D. Ill. Mar. 10, 1992); *Oil, Chem., Atomic Workers' Int'l Union v. Amoco Corp.*, No. 93 C 5929, 1997 WL 11233 (N.D. Ill. Jan. 9, 1997); *Carnagua v. Link-Belt Co.*, No. 1:04-CV-1566-LJM-JMS, 2007 WL 2904544 (S.D. Ind. Sept. 28, 2007); *Boeing Co. v. March*, 656 F. Supp. 2d 837, 863 (N.D. Ill. 2009); *Leannah v. Alliant Energy Corp.*, 607 F. Supp. 2d 946, 954 (E.D. Wis. 2009).

[17] *Struble*, 732 F.2d at 331; *Skinner*, 188 F.3d at 130; *PPG*, 236 F. App'x at 789 (consolidating the summary judgment dispositions of *UFCWU v. PPG Indus., Inc.*, No. 2:01CV1751, 2006 WL 895087 (W.D. Pa. Mar. 31, 2006), *USW v. PPG Indus., Inc.*, No. 2:01CV1601, 2006 WL 895090 (W.D. Pa. Mar. 31, 2006), and *Local Lodge 470 of Dist. 161 v. PPG Indus., Inc.*, No. CIV.A. 01-2110, 2006 WL 901927 (W.D. Pa. Mar. 31, 2006)); *Wallitsch v. Corona Corp.*, No. CIV. A. 87-2239, 1988 WL 30037 (E.D. Pa.

Of greater concern, however, is the likelihood that a standard focused on resolving ambiguities will revive the rules of construction that have followed the *Yard-Man* inference. Although *Yard-Man* purports to follow normal rules of contract construction, it encourages word play about whether CBAs are ambiguous, and has spawned canons of construction to resolve those ambiguities that fly in the face of the congressional decision rejecting mandatory vesting of welfare benefits. (*See* Part I.B. above.) Only by requiring "clear and express language" to find vesting can the Court fulfill the congressional intent and forestall further circuit conflicts.

II. THE INFERENCE OF VESTED RETIREE HEALTH BENEFITS IMPOSES A SEVERE AND INTRACTABLE BURDEN ON EMPLOYERS.

A. Vested Retiree Health Benefits Impose a Huge Financial Cost on the Employer.

A regime inferring that retiree health benefits are vested would impose oppressive costs on the Nation's employers. Obviously, vesting means the company must pay benefits for the remainder of each individual retiree's life. With even a few hundred retirees, the annual cash flow impact can be millions of dollars, in good times and bad. Moreover, the cost of health benefits has been rising at several multiples of

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Sept. 29, 1988); *Local 56, UFCWU v. Campbell Soup Co.*, 898 F. Supp. 1118 (D.N.J. 1995); *Lewis v. Allegheny Ludlum Corp.*, No. CIV. A. 11-1619, 2012 WL 1328360 (W.D. Pa. Apr. 17, 2012).

the core inflation rate for decades. And many manufacturers, like the Nation as a whole, are seeing their retired populations grow in relation to their active work forces, meaning that fewer and fewer active workers must produce sufficient profits to pay the ever-increasing health care costs of retirees.

The annual cash flow impact, though large, is not the most severe financial impact of vested retiree health benefits. The financial statement impact is much larger. In December 1990, the Financial Accounting Standards Board ("FASB") issued Statement 106, which requires employers to report in their financial statements their Accumulated Projected Benefit Obligations ("APBO"). FASB Statement 106 "focuses principally on postretirement health care benefits."[18] Post-retirement benefits are also referred to as "Other Post-retirement Employment Obligations" ("OPEB"). In short, FASB 106 requires employers to "reflect on their balance sheets the present value of estimated future costs for retirees' medical benefits." *Wise*, 986 F.2d at 932.

As of the beginning of 2006, the unfunded retiree healthcare liability for the Standard & Poor's 500 was estimated at ***$321 billion***, more than twice the unfunded pension plan liability for those firms.[19]

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[18] FASB, Summary of Statement No. 106 (Dec. 1990), *available at* www.fasb.org/st/summary/stsum/06.shtml.

[19] Stephen Moehrle, *Understanding Disclosures of Postretirement Healthcare Obligations*, CPA Journal (Sept. 2007) (citing Ian McDonald, *Health Benefits Ail as Pensions Health*, Wall St. J., June 6, 2006, *available at* www.nysscpa.org/cpajournal/2007/907/essentials/p36.htm). The underlying review of the S&P 500 is found in Howard Silverblatt and Dave Gua-

Although the booking of the liabilities by itself does not alter the company's cash flow, FASB 106 obligations affect credit worthiness as well as market and shareholder perceptions of the health of the company. Deeming these retiree health obligations vested and effectively unalterable is a severe constraint on a business.

For example, in 2004, General Motors Corporation, headquartered in the Sixth Circuit, reported APBO liability of $77 billion, of which $61 billion was attributable to UAW retirees. *UAW v. Gen. Motors Corp.*, No. 05-CV-73991-DT, 2006 WL 891151, at *3 (E.D. Mich. Mar. 31, 2006). GM's market capitalization at that time was only $15 billion. *Now for the Reckoning*, The Economist, at 72 (Oct. 13, 2005). Faced with GM's rapidly deteriorating financial situation and a threat by GM to implement unilateral changes to the retiree health benefits, the UAW agreed to negotiate about the retiree benefits on the condition that GM "fully open its books and share its complete financial data with the UAW." *Gen. Motors*, 2006 WL 891151 at *3. The negotiations proceeded against the backdrop of the *Yard-Man* inference, *id.* at *15, and ultimately required a class action settlement, approved by Judge Robert H. Cleland of the Eastern District of Michigan, to achieve resolution, *id.* at *37 (approving benefit reductions as a class action settlement). Unfortunately, the revisions were

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rino, *S&P 500 2012 Pensions and Other Post Employment Benefits (OPEB): The Final Frontier*, S&P Dow Jones Indices 7–8 (July 31, 2013), *available at* http://www.spindices.com/documents/research/sp-500-2012-pensions-and-opeb-201307.pdf.

not sufficient to save GM, which entered Chapter 11 just three years later.

In 2008, Chrysler LLC also employed the class action device to obtain a negotiated resolution of its vested benefits. At that time, Chrysler's health care benefit obligations were approximately $2.3 billion a year, "the largest portion" of which was "attributable to UAW employee and retiree health care." *Int'l Union, UAW v. Chrysler LLC*, No. 07-CV-14310, 2008 WL 2980046, at *5 (E.D. Mich. July 31, 2008). Like GM, in 2009 Chrysler sought Chapter 11 reorganization.

These retiree health care obligations impose severe restrictions on the ability of employers to operate. For example, Judge Cleland found perceptions by financial institutions of these obligations "adversely affects Chrysler's creditworthiness," *id.*, and "[t]he overall impact of Chrysler's OPEB obligation for health care is expected to continue to limit the company's access to unsecured capital resources, substantially contributing to Chrysler's precarious financial condition," *id.* at *6. Ford Motor Company recently reported that its retiree health plan "impose[s] significant liabilities on Ford that are not fully funded and will require additional cash contributions, which could impair our liquidity." *See* Ford Motor Co., Annual Report (Form 10-K), at 14 (Feb. 19, 2014).

B. The *Yard-Man* Rule Undermines Attempts by Employers To Negotiate Reductions in Vested Retiree Health Benefits.

Logic and experience show that the *Yard-Man* rule also skews the collective bargaining dynamic. Employers facing burdensome retiree health care costs have the option, if those costs are not vested, to implement reasonable modifications of those costs, often in negotiation with the unions. Reducing the benefits does not necessarily entail their complete elimination. In recent years, employers have reduced their employee health care costs by negotiating increased premiums, deductibles, and copayments with union representatives. *See* U.S. Gov't Accountability Office, GAO-06-285, *Employee Compensation* 4 (Feb. 2006). When successful, these tactics have allowed companies to remain competitive while still providing some health benefits to employees and retirees. *See, e.g.*, Steven Greenhouse, *Two Units of AT&T Reach Pacts With Union*, N.Y. Times, July 23, 2012, at B3.

With the *Yard-Man* inference as leverage, however, unions need not negotiate about retiree health benefits, allowing silence and the inference of vesting to achieve their ends. *See, e.g.*, *Gen. Motors*, 2006 WL 891151, at *3 (UAW refused to negotiate with GM about retiree health benefits until GM threatened to impose reductions unilaterally based on deteriorating financial condition, and only on condition of full access to financial records).

Even when employers succeed in negotiating limits on retiree benefits with the union, the inference that the benefits were already vested—and thus un-

alterable—*before* those negotiations can mean that any limits are swept away in subsequent litigation. *See Tackett II*, 733 F.3d at 600 (Pet. App. 20) (invalidating a negotiated cap on benefits; "[h]aving reached the conclusion that benefits were vested, it was then reasonable for the district court to conclude that those benefits could not be bargained away [by the union] without retiree permission"); *Yolton*, 435 F.3d at 583–84 (invoking *Yard-Man* inference to deem benefits vested notwithstanding a side agreement between employer and union imposing a cap on health insurance costs); *CNH Am. LLC v. UAW*, 645 F.3d 785, 788–89 (6th Cir. 2011) (describing release executed by UAW of retiree health benefit claims against CNH in exchange for CNH's $24.7 million contribution to Voluntary Employee Benefit Association; after retirees spent the money, they sued successfully to invalidate the release on the ground that the benefits were already vested before the release and claiming UAW lacked authority to negotiate reductions).

In short, so as long as the *Yard-Man* inference of vested retiree health benefits hangs over the bargaining table, unions will lack any incentive to negotiate about the issue. Even if they do negotiate, employers will lack confidence that concessions will survive if challenged by retirees in litigation. The result is not only continued financial burdens on the companies subjected to the inference, but a degradation of the collective bargaining relationship because a critically important issue is taken off the table.

C. Under *Yard-Man*, Bankruptcy May Be the Only Effective Resort for Employers To Reduce Vested Retiree Health Benefits.

Unable to reduce the retiree health benefits unilaterally as envisioned by Congress in ERISA, and faced with unions unwilling to bargain because of the *Yard-Man* inference, Chapter 11 of the Bankruptcy Code has become an all too real option. For example, in 2005, Michigan-based Delphi Corp., the world's largest maker of automobile parts, declared bankruptcy after failing to reduce its retiree obligations. *See Now for The Reckoning*, *supra*, at 72. As of December 31, 2005, Delphi faced unfunded liabilities of $10.7 billion, of which approximately $2.3 billion was attributable to unfunded pension obligations and $8.4 billion was attributable to OPEB obligations.[20] Chrysler and GM, even after taking the extraordinary step of seeking to reduce their retiree health benefit obligations using a class action settlement, entered Chapter 11 on April 30, 2009, and June 1, 2009, respectively. *See, e.g.*, Affidavit of Ronald Kolka ¶ 39 & n.8, *In re Chrysler LLC*, Case 09-50002-smb (Bankr. S.D.N.Y. Apr. 30, 2009) (as of the petition date, Chrysler was obligated to provide health care benefits to more than 106,000 retirees, surviving spouses and dependents, at a total annual cost of $970 million and an actuarial cost approximately $9.87 billion on a present value basis). Other companies that sought bankruptcy protection due in large

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[20] Delphi Corp., Annual Report (Form 10-K), at 38, 40–41 (July 11, 2006).

measure to retiree health costs are Ohio's LTV Steel in 2000 and New York's Eastman Kodak in 2013. *See* Robert Guy Matthews, *W.L. Ross Agrees to Acquire Steel Assets of Bankrupt LTV*, Wall St. J., Feb. 28, 2002, at A6; Matthew Daneman, *Kodak Bankruptcy Officially Ends*, USA Today, Sept. 3, 2013, *available at* http://www.usatoday.com/story/money/business/2013/09/03/kodak-bankruptcy-ends/2759965/.

Similarly, former Michigan Treasurer Andy Dillon recently testified in the Detroit bankruptcy proceeding that retiree health care commitments were a core reason why the City filed for bankruptcy protection, and that the City's pension shortfall was not the "driving factor." Nathan Bomey & Alisa Priddle, *Dillon: Retiree Health Care, Not Pension Shortfall, a Core Reason for Detroit Bankruptcy*, Detroit Free Press, Nov. 5. 2013, *available at* http://www.freep.com/article/20131105/NEWS01/311050046/Detroit-Chapter-9-bankruptcy-eligibility-trial-Andy-Dillon-Rich-Baird; Transcript of Trial at 150:14–15, *In re City of Detroit, MI*, Case 13-53846-swr (Bankr. E.D. Mich. Nov. 8, 2013) (testimony of Andy Dillon) ("From day one, it was the unfunded health care liability that to me was really the big challenge for the city.").

Thus, faced with burdensome retiree health care costs deemed vested under the *Yard-Man* inference, and unions reluctant to negotiate sufficient reductions, bankruptcy is an all too common outcome. A rule for resolving the vesting issue in a way more consonant with the congressional intent could avoid these unfortunate results.

III. THE "CLEAR AND EXPRESS LANGUAGE" RULE WOULD BENEFIT EMPLOYERS, UNIONS, AND COURTS.

A. A Clear Rule Would Promote More Effective Collective Bargaining.

The clear and express language rule would provide guidance to both parties during collective bargaining. Each side would know what is necessary to obtain, or to avoid, unalterable benefits for retirees. As shown (Part I.B.1. above), retiree health benefits are a permissive subject of bargaining. When they know the CBA will be construed with a strong inference that retiree health benefits are vested, unions are reluctant, if willing at all, to discuss this issue at the bargaining table. If vesting depends on the actual wording of the contract, the parties go into the negotiation in a neutral position, able to use their economic weapons to achieve their bargaining priorities without the overhang of judicial inferences.

Moreover, even when employers are able to obtain concessions at the bargaining table, those concessions may not stand up in court if attacked by the affected retirees. (*See* Part II.B. above.) Under the *Yard-Man* regime, the retirees may argue that their vested benefits could not be changed at all, even by agreement with the union, leading to invalidation of any such concessions. In the Sixth Circuit, the only proven means to effectuate a collectively-bargained reduction in retiree health benefits is through the immensely burdensome device of a judicially-approved class action settlement.

B. The "Clear and Express Language" Rule Would Reduce Future Litigation and Forum Fights.

With the clear and express language rule, the parties know upon signing whether the CBA grants lifetime unalterable retiree health benefits. Disputes, which should be few, can be resolved without extensive judicial proceedings. A clear rule that is less susceptible to interpretation from court to court would also lead to fewer disputes about venue.

Under the *Yard-Man* rule, the Sixth Circuit has become a magnet for retiree health benefit litigation. Retirees and unions use the liberal venue provisions of the LMRA and ERISA to file suit in district courts within the Sixth Circuit. *See* LMRA § 301(a), 29 U.S.C. § 185(a) (2012) (granting venue "in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties"); ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2) (2012) (granting venue "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found").

Plaintiff retirees with limited connections to the Sixth Circuit have taken advantage of the *Yard-Man* rule. In this case, for example, the retiree plaintiffs worked at the Point Pleasant Polyester Plant in Apple Grove, West Virginia—plainly outside of the Sixth Circuit. *See Tackett I*, 561 F.3d at 481 (Pet. App. 91). Nevertheless, the retirees' claims were adjudicated under Sixth Circuit law.

Similarly, in *Reese*, the defendant sought a declaratory judgment in the Seventh Circuit that retirees were not entitled to lifetime healthcare benefits. 574 F.3d at 319. In addition to being the circuit where most of CNH's UAW-represented retirees had worked, CNH is headquartered in the Seventh Circuit, the CBA negotiations took place there, and CNH administers the health care plans there. *Id.* at 320. CNH's former employees responded by filing suit in Detroit, where they could benefit from the *Yard-Man* inference *Id.* Notwithstanding the great weight of venue considerations favoring the Seventh Circuit, the district court in Detroit and the Sixth Circuit nonetheless kept the case. *Id.*

The incentive to establish jurisdiction in a friendly forum is a natural and predictable consequence of the current circuit split, but it undermines the interests of judicial efficiency and economy. Forum fights "eat[] up time and money as the parties litigate, not the merits of their claims, but which court is the right court to decide those claims." *Hertz Corp. v. Friend*, 559 U.S. 77, 94 (2010). "Nothing is more wasteful than litigation about where to litigate." *Bowen v. Massachusetts*, 487 U.S. 879, 930 (1988) (Scalia, J., dissenting). Without a clear, uniform answer from this Court, parties will continue their race to the courthouse in an effort to litigate in the more favorable forum.

Finally, as explained above (*see* Part I.D), the Second and the Seventh Circuit standards would provide insufficient clarity and guidance to the circuits and lower courts. The predictable result under those standards would be continued differences

among the circuits, encouraging continued forum shopping. Only the clear and express language standard will avoid that result.

CONCLUSION

For the foregoing reasons and those in the briefs of Petitioners and the other *amici curiae* supporting Petitioners, the National Association of Manufacturers urges the Court to reverse the judgment of the Sixth Circuit and endorse the Third Circuit's "clear and express language" standard for resolving issues of vesting in collectively-bargained welfare benefit plans.

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Respectfully submitted,

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AMICUS CURIAE BRIEF

No. 13-1010

RECORD AND BRIEFS

IN THE

Supreme Court of the United States

M&G POLYMERS USA, LLC, *ET AL.*,

Petitioners,

v.

HOBERT FREEL TACKETT, *ET AL.*,

Respondents.

ON A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF *AMICUS CURIAE* WHIRLPOOL CORPORATION IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF CITED AUTHORITIES iv

STATEMENT OF INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. A CLEAR, EXPRESS, AND UNMISTAKABLE WAIVER STANDARD IS REQUIRED BY NATIONAL LABOR POLICY 5

A. ERISA Confers A Federal, Statutory Right To Amend Or Terminate Welfare Benefit Plans 5

B. Waiver Of A Statutory Right Through Collective Bargaining Must Be Clear And Unmistakable 9

C. *Yard-Man* Is Inconsistent With ERISA, National Labor Policy And The Clear & Unmistakable Waiver Standard 12

1. *Yard-Man* Is Incompatible With ERISA 13

Table of Contents

Page

2. *Yard-Man* Conflicts With National Labor Policy 16

3. *Yard-Man* Conflicts With Section 7's Neutrality Requirement 17

D. Uniform National Labor Policy Precludes Outcomes Dictated By Geography 18

II. A "REASONABLE SUGGESTION" OR "REASONABLY SUSCEPTIBLE" STANDARD IS NOT CONSISTENT WITH NATIONAL LABOR POLICY 23

A. The "Reasonable Suggestion" Standard Allows For Further Variation & Disarray Among The Courts of Appeal 24

1. The Sixth Circuit's Pension Tying Rule Is Not Indicative Of Vesting.....24

2. The Sixth Circuit's "Specific v. General" Durational Clause Rule Should Be Rejected 26

3. Various Sixth Circuit Panels Have Inconsistently Applied *Yard-Man*.....28

Table of Contents

Page

B. The Clear & Express Standard Lends Clarity To Vesting Law & Should Be Adopted.....30

C. Analysis of Extrinsic Evidence Should Be Subject To A Clear, Express, & Unmistakable Standard.....30

CONCLUSION 34

TABLE OF CITED AUTHORITIES

Page

Cases

Abbruscato v. Empire Blue Cross & Blue Shield,
274 F.3d 90 (2d Cir. 2001) 31

Aleman v. Chugach Support Servs., Inc.,
485 F.3d 206 (4th Cir. 2007) 11

Anderson v. Alpha Portland Indus.,
836 F.2d 1512 (8th Cir. 1988)..... 27

Ashcroft v. Iqbal,
556 U.S. 662 (2009)..... 12

AT&T Techs., Inc. v. Commc'ns Workers of Am.,
475 U.S. 643 (1986)..... 10

Baldwin v. Motor Components,
155 F. App'x 16 (2d Cir. 2005)..... 27

Barnhart v. Sigmon Coal Co.,
534 U.S. 438 (2002) 5

Bell Atlantic Corp. v. Twombly,
550 U.S. 544 (2007) 12

Bender v. Newell Window Furnishings, Inc.,
681 F.3d 253 (6th Cir. 2012)..... 32, 33

Bidlack v. Wheelabrator Corp.,
993 F.2d 603 (7th Cir. 1993) 15

Cited Authorities

Page

Bland v. Fiatallis N. Am., Inc.,
401 F.3d 779 (7th Cir. 2005) 31

Cent. Penn. Teamsters Pension Fund v. McCormick Dray Line, Inc.,
85 F.3d 1098 (3d Cir. 1996) 11

Cole v. ArvinMeritor, Inc.,
549 F.3d 1064 (6th Cir. 2008) 33

Curtiss-Wright v. Schoonejongen,
514 U.S. 73 (1995) ..... *passim*

Deboard v. Sunshine Mining & Ref Co.,
208 F.3d 1228 (10th Cir. 2000) 7

Dewhurst v. Century Aluminum Co.,
2009 U.S. Dist. LEXIS 120014 (S.D. Ohio Dec. 23, 2009) 20

Diehl v. Twin Disc, Inc.,
102 F.3d 301 (7th Cir. 1996).....24, 31

Dolge v. Dolge,
75 N.Y. Supp. 386 (App. Div. 1902).....13

East Tenn. Baptist Hosp. v. NLRB,
6 F.3d 1139 (6th Cir. 1992).....11

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987).....21

Cited Authorities

Page

Fraser v. Magic Chef-Food Giant Markets,
324 F.2d 853 (6th Cir. 1963) 20

Gable v. Sweetheart Cup Co.,
35 F.3d 851 (4th Cir. 1994).....6

Ginter v. Whirlpool Corp.,
2009 U.S. Dist. LEXIS 56579 (W.D. Mich. July 1, 2009) 21

Golden v. Kelsey-Hayes Co.,
73 F.3d 648 (6th Cir. 1996) 16, 25

Heheman v. E.W. Scripps Co.,
661 F.2d 1115 (6th Cir. 1981).....28

In re Lucent Death Benefits ERISA Litig.,
541 F.3d 250 (3d Cir. 2008) 5

In re Unisys Corp. Retiree Medical Benefit "ERISA" Litig.,
58 F.3d 896 (3d Cir. 1995) 32

Int'l Bhd. of Teamsters, Local 1199 v. Pepsi-Cola Gen. Bottlers, Inc.,
958 F.3d 1331 (6th Cir. 1992).....28

Int'l Chem. Workers v. PPG Indus.,
236 F. App'x 789 (3d Cir. 2012).....27

Cited Authorities

Page

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry., 520 U.S. 510 (1997) 3, 6, 8

John Morrell & Co. v. UFCW, 37 F.3d 1302 (8th Cir. 1994) 14, 25

Joyce v. Curtiss-Wright Corp., 171 F.3d 130 (2d Cir. 1999) ..... *passim*

Leiter Minerals, Inc. v. United States, 352 U.S. 220 (1957) 10

Lewis v. Allegheny Ludlum Corp., 2011 U.S. Dist. LEXIS 148584 (N.D. Ohio Dec. 21, 2011) 20

Lewis v. Benedict Coal Corp., 361 U.S. 459 (1959) 10

Lingle v. Norge Div. of Magic Chef, Inc., 486 U.S. 399 (1988) 10, 16, 23

Litton Fin. Printing Div. v. NLRB, 501 U.S. 190 (1991) 11, 20, 27

Livadas v. Bradshaw, 512 U.S. 107 (1994) 9, 17, 18

Local 65-B, Graphic Commc'ns Conference v. NLRB, 572 F.2d 342 (7th Cir. 2009) 11

Cited Authorities

Page

Local Union 1395 v. NLRB,
797 F.3d 1027 (D.C. Cir. 1986). 11

Local Union 36, IBEW v. NLRB,
706 F.3d 73 (2d Cir. 2013) 31

Loskill v. Barnett Banks, Inc.,
289 F.3d 734 (11th Cir. 2002). 6

Marine Eng'gs Beneficial Ass'n v.
GFC Crane Consultants, Inc.,
331 F.3d 1287 (11th Cir. 2003). 11

Maurer v. Joy Techs., Inc.,
212 F.3d 907 (6th Cir. 2000) 18, 26, 28, 29

Maytag Corp. v. UAW,
687 F.3d 1076 (8th Cir. 2012). . . . . *passim*

McCoy v. Meridian Auto. Sys., Inc.,
390 F.3d 417 (6th Cir. 2004). 33

McNevin v. Solvay Process Co.,
52 N.Y. Supp. 98 (App. Div. 1898). 13

Mello v. Sara Lee Corp.,
431 F.3d 440 (5th Cir. 2005) 32

Metropolitan Edison Co. v. NLRB,
460 U.S. 693 (1983). . . . . *passim*

Cited Authorities

Page

Moore v. Metro. Life Ins. Co.,
856 F.2d 488 (2d Cir. 1988) 8

NLRB v. Savair Mfg. Co.,
414 U.S. 270 (1973) 17

Noe v. PolyOne Corp.,
520 F.3d 548 (6th Cir. 2008) 26, 29

Oddie v. Ross Gear & Tool Co.,
305 F.2d 143 (6th Cir. 1962).....20

OCAW, Local 1-547 v. NLRB,
842 F.2d 1141 (9th Cir. 1988).....31

Pennhurst State Sch. & Hosp. v. Halderman,
451 U.S. 1 (1981) 10

Reese v. CNH Am., LLC,
574 F.3d 315 (6th Cir. 2009).....18, 29

Rosetto v. Pabst Brewing Co.,
217 F.3d 539 (7th Cir. 2000).....23

Ross v.
Rail Car Am. Group Disability Income Plan,
285 F.3d 735 (8th Cir. 2002) 6

Ryan v. Commodity Futures Trading Comm'n,
125 F.3d 1062 (7th Cir. 1997) 3

Cited Authorities

Page

Senn v. United Dominion Indus.,
951 F.2d 806 (7th Cir. 1992).....19, 27

Shaw v. Delta Airlines, Inc.,
463 U.S. 85 (1983)..... 21

Sigman v. Rudolph Wurlitzer Co.,
11 N.E.2d 878 (Ct. App. Ohio 1937).....13

Sloan v. BorgWarner, Inc.,
2014 U.S. Dist. LEXIS 24856 (W.D. Mich. Feb. 27, 2014).....22

Sprague v. Gen. Motors Corp.,
133 F.3d 388 (6th Cir. 1998).....18

Texas & New Orleans Ry. Co. v. Jones,
103 S.W.2d 1043 (Tex. Ct. Civ. App. 1937).....13

Timken Roller Bearing Co. v. NLRB,
325 F.2d 746 (6th Cir. 1963).....7, 30

UAW v. BVR Liquidating, Inc.,
190 F.3d 768 (6th Cir. 1999).....28

UAW v. Skinner Engine Co.,
188 F.3d 130 (3d Cir. 1999) ..... *passim*

UAW v. Yard-Man, Inc.,
716 F.2d 1476 (6th Cir. 1984)..... *passim*

Cited Authorities

Page

United Steel, Paper & Forestry, Rubber, Mfg. Energy, Allied Indus. & Service Workers Int'l Union, AFL-CIO-CLC v. Kelsey Hayes Co., 750 F.3d 546 (6th Cir. 2014) 25-26

Upholsterers' International Union v. American Pad & Textile Co., 372 F.2d 427 (6th Cir. 1967) 15

Vallone v. CNA Fin. Corp., 375 F.3d 623 (7th Cir. 2004) 6

Wise v. El Paso Natural Gas Co., 986 F.2d 929 (5th Cir. 1993) 6

Witmer v. Acument Global Techs., Inc., 694 F.3d 774 (6th Cir. 2012) 19, 29

Wright v. Universal Maritime Service Corp., 525 U.S. 70 (1998) 3, 10, 11

Yolton v. El Paso Tenn. Pipeline Co., 435 F.3d 571 (6th Cir. 2006) 19, 33

Zino v. Whirlpool Corp., 2013 U.S. Dist. LEXIS 121750 (N.D. Ohio, Aug. 27, 2013) ..... *passim*

Cited Authorities

Page

Statutes

29 U.S.C. § 157 17

29 U.S.C. § 1051(1) 5, 13

29 U.S.C. § 1102(a)(1). 3, 32

Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. 3

Other Authorities

BLACK'S LAW DICTIONARY (8th ed. 2004) 5

STATEMENT OF INTEREST OF *AMICUS CURIAE*

This Amicus Brief is submitted with the consent of the parties in support of Petitioner M&G Polymers USA, LLC.[1] Amicus Whirlpool Corporation ("Whirlpool") seeks reversal of the Sixth Circuit's decision below. Similar to the Petitioner, Whirlpool is a defendant in a case in which four subclasses of formerly union-represented retiree-plaintiffs claim they were promised a specified level of benefits for their lifetimes and the lifetimes of their surviving spouses, if any. *See Zino v. Whirlpool Corp.*, 2013 U.S. Dist. LEXIS 121750, at *8-10 (N.D. Ohio, Aug. 27, 2013).

In 2006, Whirlpool acquired one of its U.S.-based competitors, Maytag Corporation ("Maytag"). As a consequence of acquiring Maytag and its subsidiary, the Hoover Company ("Hoover"), Whirlpool became the sponsor for over 100 separate health plans. Following the purchase, Whirlpool began to harmonize and consolidate the various active and retiree health insurance plans into Whirlpool's existing plans in an effort to ease the administrative burden of overseeing hundreds of disparate benefit plans and to equalize benefits received by participants. These changes enhanced Whirlpool's ability to provide competitive, contemporary, and sustainable healthcare benefits to its employees and retirees.

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1. No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the amicus, or its counsel, made a monetary contribution intended to fund its preparation or submission. The parties have filed blanket waivers with the Court consenting to the submission of all amicus briefs.

Whirlpool focused its initial consolidation efforts on a Maytag plant in Newton, Iowa. In 2008, Whirlpool sought to negotiate with the United Auto Workers ("UAW") changes to the Newton retirees' health benefits (i.e. to transfer the Newton retirees into the Whirlpool plans). The UAW refused to bargain over Whirlpool's proposed changes, whereupon Whirlpool brought suit in the Southern District of Iowa. *See Maytag Corp. v. UAW*, 687 F.3d 1076 (8th Cir. 2012). Ultimately, the Eighth Circuit concluded the Newton retirees did not have a contractual right to vested benefits (*id.*), and Whirlpool proceeded to transfer the Newton retirees to its retiree plan, which currently provides healthcare benefits to over 19,000 Whirlpool retirees.

Also in 2008, Whirlpool terminated an expiring collective bargaining agreement, along with all its constituent parts, between Hoover and IBEW Local 1985 that covered employees at a plant in Canton, Ohio. Unlike at Newton, no collective bargaining relationship existed there due to the sale of Hoover to Techtronic Industries ("TTI") in 2007. In 2011, Whirlpool unilaterally announced its plan to harmonize the Hoover retiree benefits with Whirlpool's retiree benefits. Soon thereafter, the Hoover retirees filed suit in the Northern District of Ohio, claiming that various labor agreements had promised them vested benefits at specified levels for their lifetimes. *See Zino*, 2013 U.S. Dist. LEXIS 121750, at *8. By sheer happenstance of living in the Sixth Circuit, the Hoover retirees benefit from a substantial body of retiree-friendly (but, as discussed below, ultimately incorrect and unsustainable) case law based solely on their geographic location.

Whirlpool is uniquely positioned to share with the Court its experience of confronting two lawsuits of the same type, albeit with the potential for widely disparate results based simply on the geographical location of the affected retiree population. Whirlpool thus respectfully submits the following brief as an amicus of the Court. *See Ryan v. Commodity Futures Trading Comm'n*, 125 F.3d 1062, 1063 (7th Cir. 1997) ("An amicus brief should normally be allowed . . . when the amicus has an interest in some other case that may be affected by the decision in the present case . . . or when the amicus has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide.").

SUMMARY OF ARGUMENT

The Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq., is a comprehensive and detailed statutory scheme. It exempts welfare benefits both from its vesting regime and from its anti-cutback rules, thus granting plan sponsors the ***right*** to amend, modify, or discontinue welfare benefit plans. *See Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995); *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997). ERISA also requires plans to be in writing. 29 U.S.C. § 1102(a)(1).

In both *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693, 708 (1983) and *Wright v. Universal Maritime Service Corp.*, 525 U.S. 70, 80 (1998), the Court held, as a matter of federal common law, that waiver of a federal, statutory ***right*** via the collective bargaining process must be "clear and unmistakable." Consequently, the federal common law

of collective bargaining agreements requires that waiver of an employer's ERISA-conferred rights to modify or terminate welfare benefits be expressed in clear and unmistakable language.

To the extent that waiver of this statutory right is characterized as an "agreement to vest retiree benefits" (the flip side of the same coin), the "clear and express" standard, as articulated by the Third Circuit in *UAW v. Skinner Engine Co.*, 188 F.3d 130, 139 (3d Cir. 1999), should be adopted. In other words, both the employer's promises (i) to vest retiree healthcare benefits for the life of a retiree and (ii) at specified levels must be expressed in clear and unmistakable terms. The Court should adopt the clear and unmistakable language standard because it is consistent with the Court's prior decisions addressing waiver of statutory rights through collective bargaining and because it is consistent with both the text and intent of ERISA, which expressly and intentionally exempts welfare benefits both from its vesting regime and from its prohibitions against reductions (i.e. the anti-cutback rules).

The Court, moreover, should reject the "reasonable suggestion" or "reasonably susceptible" standard applied by the Second and Seventh Circuits. This standard is vague and does not provide any genuine clarity to the inconsistent vesting standards and competing contract interpretation rules adopted by the various circuits. In any event, the Court should reject the Sixth Circuit's body of precedent based on *UAW v. Yard-Man* and its progeny, as *Yard-Man*'s classification of retiree health benefits as "status" benefits and its characterization of retiree benefits as "delayed compensation" all run contrary to

ERISA's express language and contravene national labor policy.

ARGUMENT

I. A CLEAR, EXPRESS, AND UNMISTAKABLE WAIVER STANDARD IS REQUIRED BY NATIONAL LABOR POLICY[2]

A. ERISA Confers A Federal, Statutory Right To Amend Or Terminate Welfare Benefit Plans

It is axiomatic that while ERISA makes employee ***pension*** benefits inviolate through its vesting rules and anti-cutback prohibitions, the statute expressly and deliberately excludes ***health and welfare*** benefits from these two strictures. *See* 29 U.S.C. § 1051(1) (ERISA's vesting, participant, and anti-cutback provisions do not apply to "employee welfare benefit plans"); *Curtiss-Wright v. Schoonejongen*, 514 U.S. 73, 78 (1995); *In re Lucent Death Benefits ERISA Litig.*, 541 F.3d 250, 253-54 (3d Cir. 2008) (discussing distinction between pension and welfare benefits for ERISA accrual and vesting purposes). *See also Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002) ("[I]t is a general principle of statutory construction that when 'Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.'") (citations omitted)

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2. As used herein, the words "clear", "express", and "unmistakable" are considered synonymous and carry the same meaning. *See* BLACK'S LAW DICTIONARY 620 (8th ed. 2004) (defining term "express" as "Clearly and unmistakably communicated").

By exempting health and welfare plans from its vesting and anti-cutback rules, ERISA grants plan sponsors the unfettered, statutory right to terminate or modify such plans and to discontinue or decrease any benefits provided thereunder. Indeed, both the Court and several federal appellate courts have recognized an employer's ability to terminate or modify welfare benefits plans as a "right" granted under ERISA. *See, e.g.*, *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997) ("The right that an employer or plan sponsor may enjoy in some circumstances to unilaterally amend or eliminate its welfare benefit plan . . . ."); *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 133 (2d Cir. 1999) (under ERISA, "an employer has the right to terminate or unilaterally amend [a welfare] plan at any time"); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 138 (3d Cir. 1999) (employers may "relinquish their right to unilaterally terminate [welfare] benefits and provide for lifetime vesting"); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994) ("[E]mployers have a statutory right to 'amend the terms of the plan or terminate it entirely.'") (citation omitted); *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 937 (5th Cir. 1993) (employer can waive "its statutory right to modify or terminate benefits" if such waiver is "stated in clear and express language"); *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 637 n.8 (7th Cir. 2004) (recognizing an employer's "right" to terminate or modify plan); *Ross v. Rail Car Am. Group Disability Income Plan*, 285 F.3d 735, 741 (8th Cir. 2002) (under ERISA, company has "the unilateral right to amend" disability insurance plan); *Loskill v. Barnett Banks, Inc.*, 289 F.3d 734, 737 (11th Cir. 2002) (employers are generally free to adopt, modify, or terminate welfare plans unless the employer "contractually cedes any of those rights"). *See*

also Curtiss-Wright Corp., 514 U.S. at 78 (employers are "generally free . . . for any reason and at any time to adopt, modify, or terminate welfare plans").[3]

ERISA's plain language and legislative history make clear that Congress intentionally omitted welfare benefit plans from ERISA's automatic vesting and anti-cutback provisions and purposefully granted employers the right to change such plans. As the Court has observed:

> The flexibility an employer enjoys to amend or eliminate its welfare plan is not an accident; Congress recognized that "requiring the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans." Giving employers this flexibility also encourages them to offer more generous benefits at the outset, since they are free to reduce benefits should economic conditions sour. If employers were locked into the plans they initially offered, "They would err initially on the side of omission."

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3. The Tenth Circuit holds an employer may change or modify benefits only if the plan reserves that right. *See Deboard v. Sunshine Mining & Ref. Co.*, 208 F.3d 1228, 1239 (10th Cir. 2000). This is clearly a minority view and undoubtedly an incorrect one. An employer's right to offer, modify, or discontinue welfare benefit plans is a right independent of contract; it is one expressly conferred by statute, and thus there is no need to memorialize it in writing. *See, e.g., Timken Roller Bearing Co. v. NLRB*, 325 F.2d 746, 751 (6th Cir. 1963) (union entitlement to wage information was a "right" under the NLRA, and rejecting contention that such a right could only be obtained through contract).

520 U.S. at 515 (internal citation omitted) (quoting S. Rep. No. 93-383, at 51 (1973)). *See also Moore v. Metro. Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) ("With regard to an employer's *right to change medical plans*, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans.") (emphasis added).[4]

The right to terminate or modify welfare benefit plans, however, is not absolute. An employer may waive that right via contract. *See* 520 U.S. at 515 ("[U]nless an employer contractually cedes its freedom . . ., it is generally free under ERISA, for any reason at any time, to adopt, modify, or terminate [its] welfare plan.") (internal citations and quotations omitted). As discussed below, both national labor policy and the federal common law of collective bargaining compel the conclusion that an employer's waiver of its ERISA rights to amend or terminate welfare benefits must occur through clear, express, and unmistakable language.

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4. The policy reasons underlying Congress' decision to exempt welfare benefits from ERISA's vesting provision were extraordinarily prescient. The cost of prescription drugs for retirees has skyrocketed. This is no surprise, given the explosion in the types of prescription drugs available on the market and covered by prescription drug plans. A comparison of the formulary for the Hoover retirees' drug plan in 1992 and the formulary for the Hoover Medicare retirees' drug plan in 2014 is telling. The former lists both covered and non-covered drugs in two pages. The latter list of covered drugs is over 100 pages long. *Compare* Exhibit 1 *to* Express Scripts Medicare 2014 Formulary, *available at* http://www.carehealthplan.com/formulary/2014/2014ESIFormulary.pdf (last visited July 23, 2014).

B. Waiver Of A Statutory Right Through Collective Bargaining Must Be Clear And Unmistakable

The Third Circuit's clear and express vesting standard echoes a deeply embedded and well-established national labor policy: namely, that waiver of a statutory right through the collective bargaining process must be clear and unmistakable. The genesis of this policy is found in the Court's decision in *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693 (1983). There, the issue was whether the labor agreement allowed the employer to more severely discipline union officials than rank and file employees for the same misconduct. The Court found the labor agreement did not permit disparate treatment because it did not contain a *clear and unmistakable* waiver of the statutory prohibition against discrimination in the National Labor Relations Act ("NLRA"). Specifically, the Court held:

> We will not infer from a general contractual provision that the parties intended to waive a statutorily protected right unless the undertaking is "explicitly stated." More succinctly, the waiver must be clear and unmistakable.

460 U.S. at 708.[5] *See also Livadas v. Bradshaw*, 512 U.S. 107, 125 (1994) (noting in dictum that if a union purported

5. Appearing as an affiliate of the IBEW in *Metropolitan Edison*, the AFL-CIO urged the Court to adopt the clear and unmistakable waiver standard. *See* Resp't Br., No. 81-1664, 1982 U.S. S. Ct. Briefs LEXIS 45, at *10-11, *39-41 (Oct. 30, 1982). Having prevailed in *Metropolitan Edison*, the AFL-CIO cannot now object to the adoption of that same standard in this matter.

to bargain away a member's rights under California wage and hour laws, such a waiver "would . . . have to be clear and unmistakable"); *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 409 n.9 (1988) (noting in dictum that waiver of state-law rights must be shown through "clear and unmistakable evidence") (internal citations and quotations omitted); *AT&T Techs., Inc. v. Commc'ns Workers of Am.*, 475 U.S. 643, 656 (1986) (parties must "clearly and unmistakably" agree to submit question of arbitrability to arbitrator). *Cf. Lewis v. Benedict Coal Corp.*, 361 U.S. 459, 471 (1959) (holding that parties to a collective bargaining agreement must express undertakings in "unequivocal words").[6]

Demonstrating that *Metropolitan Edison* was not an anomaly, the Court applied the same clear and unmistakable standard to the waiver of a federal statutory right through collective bargaining in a different context. In *Wright v. Universal Maritime Service Corp.*, 525 U.S. 70 (1998), the Court addressed whether a general arbitration clause in a collective bargaining agreement operated to waive an employee's statutory right to bring federal employment discrimination claims in a judicial forum. The Court held that the clear and unmistakable waiver standard applied, even though the right at issue was a procedural, as opposed to a substantive, one. *See*

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6. A similar standard has been adopted by the Court elsewhere. *See, e.g., Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[I]f Congress intends to impose a condition on the grant of federal moneys [under its spending power], it must do so unambiguously"); *Leiter Minerals, Inc. v. United States*, 352 U.S. 220, 224 (1957) (a statute that divests pre-existing rights or privileges will not be applied to a sovereign in absence of "express words to that effect").

id. at 80 (the statutory right to a federal judicial forum was "of sufficient importance to be protected against less-than-explicit union waiver in the CBA").

In keeping with both *Metropolitan Edison* and *Wright*, the federal appellate courts have applied a clear and unmistakable standard to the waiver of federal statutory rights through the collective bargaining process.[7] *See, e.g., Cent. Penn. Teamsters Pension Fund v. McCormick Dray Line, Inc.*, 85 F.3d 1098, 1109 (3d Cir. 1996) (applying clear and unmistakable waiver standard to pension fund's ERISA right to collect delinquent monies); *Aleman v. Chugach Support Servs., Inc.*, 485 F.3d 206, 216 (4th Cir. 2007) (labor agreement clearly and unmistakably waived right to judicial forum for Title VII and Section 1981 claims); *East Tenn. Baptist Hosp. v. NLRB*, 6 F.3d 1139, 1144 (6th Cir. 1992) (employer did not clearly and unmistakably waive confidentiality defense to union request for information under NLRA); *Local 65-B, Graphic Commc'ns Conference v. NLRB*, 572 F.3d 342, 351 (7th Cir. 2009) (union clearly and unmistakably waived right to bargain over rules of conduct and performance standards); *Marine Eng'gs Beneficial Ass'n v. GFC Crane Consultants, Inc.*, 331 F.3d 1287, 1293 (11th Cir. 2003) (employer did not clearly and unmistakably waive right to terminate labor agreement); *Local Union 1395 v. NLRB*, 797 F.2d 1027, 1032 (D.C. Cir. 1986) (applying clear and unmistakable standard to waiver of right to sympathy strike).

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7. As the DC Circuit observed, this standard applies regardless of whether the case arises out of Section 301 of the Labor Management Relations Act or out of an unfair labor practice under Section 8 of the NLRA. *See Local Union 1395 v. NLRB*, 797 F.2d 1027, 1032 (D.C. Cir. 1986). *See also Litton Fin. Printing Div. v. NLRB*, 501 U.S. 190, 203 (1991).

It is thus well-settled under the federal common law of collective bargaining agreements that waiver of a federal statutory right via the collective bargaining process must be clear and unmistakable. Plainly then, in order for an employer to relinquish its substantive ERISA rights to change or terminate welfare benefit plans through collective bargaining and commit to providing lifetime retiree benefits at fixed, unalterable levels, the parties must adopt clear and unmistakable language conveying the intention to do so. This standard, which has been adopted elsewhere by the Court and by the Third Circuit in the context of retiree benefits, is aligned with national labor policy and comports with the intent of ERISA. Accordingly, it should be adopted by this Court.[8]

C. *Yard-Man* Is Inconsistent With ERISA, National Labor Policy And The Clear & Unmistakable Waiver Standard

In *UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1984), the Sixth Circuit held that contractual silence as to the duration of retiree healthcare benefits may nonetheless give rise to an intent to vest. *Id.* at 1481 n.2 (noting that while an expression of intent to offer retiree benefits must be clear, no clear expression of intent is necessary regarding the duration of those benefits). As originally framed, the *Yard-Man* inference, as it has come to be known, rests partly upon the notion that retiree benefits are "status" benefits and partly upon the notion

8. The clear and unmistakable waiver standard should apply to all waivers, just as the *Twombly* pleading standard applies to all pleadings. *See Ashcroft v. Iqbal*, 556 U.S. 662, 680 (2009) (explaining pleading standard of *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007) applied generally).

that retiree benefits are a form of "delayed compensation." 716 F.2d at 1482. The *Yard-Man* inference is completely at odds with ERISA, with federal labor policy and with the clear and unmistakable waiver standard. Accordingly, the Court should explicitly repudiate both the *Yard-Man* inference and its underpinnings.

1. *Yard-Man* Is Incompatible With ERISA

The two notions underlying the *Yard-Man* inference–(1) that retiree benefits are "status" benefits and (2) that retiree benefits are a form of "delayed compensation"–are merely vesting principles in disguise. The argument that healthcare benefits presumptively vest by virtue of being conferred upon a retiree is flatly contrary to the plain language and intent of ERISA, which explicitly exempts health and welfare benefits from its vesting provisions. *See* 29 U.S.C. § 1051(1). Likewise, by characterizing retiree healthcare benefits as a form of "delayed compensation," *Yard-Man* improperly conflates those benefits with pension benefits. Again, this is entirely inconsistent with ERISA, which expressly distinguishes pension benefits and welfare benefits for purposes of vesting.[9] There is an

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9. In the early twentieth century, the common law considered employer-funded pensions "gratuities" or "inchoate" gifts. *See, e.g., McNevin v. Solvay Process Co.*, 52 N.Y. Supp. 98 (App. Div. 1898); *Dolge v. Dolge*, 75 N.Y. Supp. 386 (App. Div. 1902). As such, employers enjoyed the right to revoke plans and recover pension plan assets. *Id.* Later, the courts began to afford pension benefits more protection by treating benefits as "deferred wages" to which an employee was contractually entitled in exchange for his years of service. *See, e.g., Sigman v. Rudolph Wurlitzer Co.*, 11 N.E.2d 878 (Ct. App. Ohio 1937); *Texas & New Orleans Ry. Co. v. Jones*, 103 S.W.2d 1043 (Tex. Ct. Civ. App. 1937). Eventually, Congress

element of a "Catch-22" to the Sixth Circuit's logic. As a practical matter, a benefit must be offered before it can be amended or terminated. *Yard-Man* holds, however, that the mere act of offering retiree health benefits results in the automatic erosion of the right to amend or terminate them, a consequence incompatible with ERISA and with *Metropolitan Edison*'s holding that waivers of statutory rights will not be inferred from general contract language. 716 F.2d at 1481 n.2; 460 U.S. at 708.

Yard-Man, moreover, premised its "delayed compensation" theory on the fact that retiree benefits are a permissive, as opposed to mandatory, subject of bargaining. 716 F.2d at 1482. The Sixth Circuit reasoned that because unions are not obligated to bargain on behalf of retirees, "it is unlikely that such benefits . . . would be left to the contingencies of future negotiations." *Id.* [10] The court, however, drew this inference despite unambiguous contract language providing that retirees would receive "benefits equal to active group benefits." *Id.* at 1480. Thus, even though the plain language of the agreement in *Yard-Man* exposed retirees' benefits to future exigencies by virtue of equating them to active employee benefits, the Sixth Circuit disregarded this language and created

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passed ERISA, which codified–to a certain extent–the "contract theory" of pensions and imposed vesting requirements and other minimum standards on employers who chose to offer pension plans. Congress, however, did not impose these same requirements on unfunded, health and welfare plans.

10. But as Maytag's experience at its Newton facility demonstrated, unions in fact engage in bargaining on behalf of retirees. *See Maytag* 687 F.3d at 1084 n.7; *see also John Morrell & Co. v. UFCW*, 37 F.3d 1302, 1307 (8th Cir. 1994).

a rule inconsistent with the parties' express intent. As both the Third and Seventh Circuits have concluded, the more compelling and rationale argument is that if active employees nearing retirement do not want their retirement benefits subject to future uncertainties, they can insist on specific contractual language vesting their retiree benefits. *See Skinner*, 188 F.3d at 141; *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 609 (7th Cir. 1993).

Finally, the genesis of the theory that retiree welfare benefits are "status" benefits or "delayed compensation" appears in the Sixth Circuit's *pre-ERISA* decision, *Upholsterers' International Union v. American Pad & Textile Co.*, 372 F.2d 427 (6th Cir. 1967). There, the Sixth Circuit held that a promise to provide retiree life insurance benefits (a welfare benefit) survived the expiration of a labor agreement because "the employee service called for [under the contract] is fully performed." *Id.* at 428. Thus, the court held retirees received vested life insurance benefits if they completed the requisite years of service and reached the age limits prescribed by the labor agreement.

Subsequently, in 1974, ERISA was enacted and, as discussed in Part I.A above, both its plain text and legislative history confirm that Congress exempted welfare benefits from its vesting regime and anti-cutback prohibitions. The Sixth Circuit, however, simply ignored this legislative mandate and created the *Yard-Man* inference, even though it was premised upon a flawed foundation (i.e. *American Pad & Textile Co.*). Indeed, when pressed to revisit *Yard-Man* in light of Supreme Court precedent (including the *Curtiss-Wright* decision), the Sixth Circuit brushed aside those arguments, dismissively

noting that *Curtiss-Wright* bore "no relation to the issues in *Yard-Man*." *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 655 (6th Cir. 1996).

2. *Yard-Man* Conflicts With National Labor Policy

Yard-Man, moreover, conflicts with national labor policy, which calls for the creation of a uniform set of interpretative rules applicable to collective bargaining agreements. *See Lingle*, 486 U.S. at 404 ("[Section] 301 mandates resort to federal rules of law in order to ensure uniform interpretation of collective-bargaining agreements, and thus to promote the peaceable, consistent resolution of labor-management disputes."). As discussed in Part I.B above, federal common law has long held that waiver of a federal statutory right via bargaining must clear and unmistakable and that waiver will not be inferred from contractual silence or from general provisions. *Metropolitan Edison*, 460 U.S. at 708.

Under *Yard-Man*, however, an employer may forfeit the statutory right to change or terminate retiree healthcare benefits through mere silence or through a general reference to retiree benefits. *Yard-Man*, in other words, creates a double standard. Unlike other statutorily conferred rights, the ERISA rights to modify or discontinue welfare benefits can be sacrificed by silence or ambiguity in the labor agreement. There thus exist differing interpretative standards depending on the nature of the federal right at issue–a result that frustrates national labor policy's goals of consistency and uniformity in the interpretation of collective bargaining agreements. *Yard-Man*, therefore, should be overruled and replaced by the clear and unmistakable waiver standard adopted by

this Court or, alternatively, the clear and express vesting standard adopted by the Third Circuit.

3. *Yard-Man* Conflicts With Section 7's Neutrality Requirement

Although the *Yard-Man* court acknowledged that its decision had to be consistent with federal labor policy, it never tested its inference against that policy. 716 F.2d at 1480. Had such testing occurred, the Sixth Circuit would have recognized its inference fails that test. Section 7 of the National Labor Relations Act grants employees the right to "form, join, or assist" labor unions while simultaneously conferring the right "to refrain from any or all such activities." 29 U.S.C. § 157. Entrenched in this statutory provision is the principle of neutrality, meaning that Section 7 protects the free choice of an employee to join–or not to join–a labor union. *See NLRB v. Savair Mfg. Co.*, 414 U.S. 270, 278 (1973). As the Court has held, rules of law that penalize an employee for union membership (or lack thereof) or that otherwise have detrimental effects on employees' Section 7 rights are impermissible. *See, e.g., Livadas*, 512 U.S. at 117 (voiding a California policy refusing to enforce wage claims brought by unionized employees because the state's policy forced employees to choose between having their state law rights enforced or exercising their Section 7 rights to enter into collective bargaining agreements).

The Sixth Circuit's retiree healthcare precedent runs contrary to Section 7's guarantee of neutrality. Under current Sixth Circuit law, unrepresented retirees do not enjoy the advantage of the *Yard-Man* inference. Rather, in the non-union context, an employer's intent to vest retiree healthcare benefits "must be found in the

plan documents and must be stated in clear and express language." *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 400 (6th Cir. 1998). Unionized retirees, however, do not bear the more onerous burden of proving a clear and express intent to vest. *See Maurer v. Joy Techs., Inc.*, 212 F.3d 907, 915 (6th Cir. 2000) ("Courts can find that rights have vested under a CBA even if the intent to vest has not been explicitly set out in the agreement."). In fact, union-represented employees receive a "nudge" or "thumb on the scale" in favor of vesting based solely on their union membership. *Reese v. CNH Am., LLC*, 574 F.3d 315, 321 (6th Cir. 2009); *Yardman*, 716 F.2d at 1482. The Sixth Circuit's disparate vesting standards as applied to union and non-union retirees cannot be reconciled with Section 7's mandate of neutrality and, therefore, must fail. *Cf. Livadas*, 512 U.S. at 117.

Ultimately, the *Yard-Man* inference is built upon an untenable foundation. It is incompatible with the text and intent of ERISA, with national labor policy's core principles of uniformity and neutrality, and with the Court's clear and unmistakable waiver precedent. *Yard-Man* was wrongly decided and should be rejected in favor of the Court's clear and unmistakable waiver standard (or as restated by the Third Circuit: a clear and express vesting standard).

D. Uniform National Labor Policy Precludes Outcomes Dictated By Geography

Because the federal district and appellate courts have wandered into the thicket of "vesting" rather than hewing to the open road of "waiver," the body of federal common law governing the vesting of retiree healthcare benefits, as it currently exists in the federal courts, is anything but

homogenous. This jumble of competing formulae is often inconsistently applied by different panels of the same court and flies in the face of both ERISA's and national labor policy's twin goals of uniformity and consistency.

As set forth in the question presented to the Court, three predominant, yet entirely different, vesting standards have emerged: specifically, the Sixth Circuit's *Yard-Man* "nudge," the Third Circuit's "clear and express" standard, and the Second and Seventh Circuits' "reasonably supported" standard. Moreover, regardless of the standard applied, the federal appellate courts have developed distinct–and at times contradictory–interpretative tools to evaluate collective bargaining agreements and the extent to which contract language gives rise to an intent to vest retiree benefits. *Compare Witmer v. Acument Global Techs., Inc.*, 694 F.3d 774, 776 (6th Cir. 2012) ("Language tying health care benefits to retirement-income benefits, we have held, demonstrates the parties' intent to create vested healthcare benefits") *with Joyce*, 171 F.3d at 134 (tying benefits eligibility to pension eligibility could not "reasonably be read as binding [the employer] to vest the benefits at issue"). *Compare Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 581 (6th Cir. 2006) ("[a]bsent specific durational language referring to retiree benefits themselves, courts have held that the general durational language says nothing about those retiree benefits") *with Senn v. United Dominion Indus.*, 951 F.2d 806, 816 (7th Cir. 1992) ("The default rule in this Circuit is that entitlements established by [CBAs] do not survive their expiration or modification . . . the logical interpretation under our rule is that benefits 'will continue' for the duration of the contract.") *and Skinner*, 188 F.3d at 141 (interpreting contract as providing retiree

benefits through its expiration date "appears to be the more reasonable [interpretation] in light of the durational provisions in all of the CBAs"). [11]

As a result of the divergent standards and interpretive rules adopted by the federal circuits, the outcome of a vesting lawsuit is largely dictated by geography. This, in turn, has led to rampant forum shopping, with plaintiffs racing to the Sixth Circuit to take advantage of the *Yard-Man* inference and of its retiree-friendly jurisprudence. *See, e.g., Lewis v. Allegheny Ludlum Corp.*, 2011 U.S. Dist. LEXIS 148584, at *3-4 (N.D. Ohio Dec. 21, 2011) ("[p]laintiffs have engaged in forum shopping simply in order to capitalize on a unique precedent in the Sixth Circuit"); *see also Dewhurst v. Century Aluminum Co.*, 2009 U.S. Dist. LEXIS 120014 (S.D. Ohio Dec. 23, 2009). Whirlpool has experienced such gamesmanship firsthand. In the *Maytag* litigation, Whirlpool filed a declaratory judgment action in the Southern District of Iowa, seeking a declaration that it had the right to change the Newton retiree benefits under the terms of the collective bargaining agreement. 687 F.3d at 1080. In response, the Newton retirees paired with retirees from a plant in Kentucky and filed a "mirror-image" lawsuit in the Western District of Michigan in a blatant attempt to hale

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11. This "default rule" would appear to be required by the Court's decision in *Litton*. *See* 501 U.S. at 207 ("contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement . . ." and agreement must "provide[] in explicit terms" that "certain benefits continue after the agreement's expiration"). In contrast to *Yard-Man* and its progeny, see *Oddie v. Ross Gear & Tool Co.*, 305 F.2d 143, 149 (6th Cir. 1962); *Fraser v. Magic Chef-Food Giant Markets*, 324 F.2d 853, 856-57 (6th Cir. 1963).

the dispute into a Sixth Circuit jurisdiction. 687 F.3d at 1080. This tactic proved unsuccessful, as the district court in Michigan ultimately transferred the later-filed case to Iowa, whereupon, after an unsuccessful mandamus action against the Michigan judge, it was promptly dismissed. *Id. See also Ginter v. Whirlpool Corp.*, 2009 U.S. Dist. LEXIS 56579 (W.D. Mich. July 1, 2009).

These geography-driven outcomes also contravene a primary purpose of ERISA: to minimize administrative and financial burdens on employers by allowing them to offer and administer nationwide benefits plans in a standardized manner. *See, e.g., Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (noting that "the most efficient way" an employer can meet his ERISA responsibilities "is to establish a uniform administrative scheme"); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105 (1983) (purpose of ERISA preemption was to "minimize . . . interference with the administration of employee benefit plans," to avoid employers "administer[ing] their plans differently in each State in which they have employees"). Simply put, employers with operations in multiple federal jurisdictions cannot, with any degree of predictability or consistency, consolidate and administer retiree benefits plans given the disparate state of the law.

The problems discussed above are exemplified by Whirlpool's experience with retiree benefits litigation. As a result of its purchase of Maytag Corporation in 2006 and its subsequent efforts to harmonize retiree benefits plans, Whirlpool has faced the threat of two lawsuits: *Maytag Corp. v. UAW*, 687 F.3d 1076 (8th Cir. 2012); *Zino v. Whirlpool Corp.*, 2013 U.S. Dist. LEXIS 121750 (N.D. Ohio Aug. 27, 2013). Although both of these cases addressed an

identical issue (i.e. whether a labor agreement promised retirees lifetime, unalterable benefits), the outcome of each case has been–and will be–largely dependent on the law of the jurisdiction in which it was filed.[12]

In *Maytag*, the Eighth Circuit held that retiree benefits had not vested, reasoning, in part that a history of bargained changes to existing retiree benefits and an unambiguous reservations of rights clause in a plan SPD trumped negotiated plan language stating that a pensioner's healthcare benefits "shall continue . . . during his life." 687 F.3d at 1085. In *Zino*, however, the Northern District of Ohio (applying Sixth Circuit law) concluded that a virtually identical reservation-of-rights clause in an SPD carried no such force, even where the negotiated plans at issue contained no durational language, much less any "lifetime" language. *Zino*, 2013 U.S. Dist. LEXIS 121750, at *67-74. In *Maytag*, the Eighth Circuit did not consider relevant the fact that eligibility for retiree healthcare benefits was linked to pension benefits. 687 F.3d at 1085. In *Zino*, the district court judge, based on her reading of Sixth Circuit precedent, determined tying benefits eligibility to pension eligibility served as evidence of vesting. *Zino*, 2013 U.S. Dist. LEXIS 121750, at *39-41.

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12. In November 2013, the parties held Phase I of a bifurcated trial in the *Zino* case, which addressed whether the retirees' benefits had vested for life (i.e. durational vesting). To date, the district court has yet to issue its ruling on Phase I, and the parties have not yet tried Phase II, which will address (to the extent a Phase II trial is necessary) whether the retirees' benefits vested at specific levels. *See also Sloan v. BorgWarner, Inc.*, 2014 U.S. Dist. LEXIS 24856, at *2 (W.D. Mich. Feb. 27, 2014) (adopting the bifurcated trial approach).

As a comparison of the *Maytag* and *Zino* cases illustrates, there exists virtually no uniformity among the federal appellate courts as to what vesting standard and what interpretative tools to apply when evaluating whether a collective bargaining agreement waives the employer's ERISA rights to modify or terminate healthcare benefits or, in other words, vests such benefits for retirees. This state of affairs undermines national labor policy, which directs the courts to fashion a uniform and consistent body of law to apply to labor-related disputes. *See Lingle*, 486 U.S. at 404. As such, it is crucial the Court apply its prior precedent and adopt the clear and unmistakable waiver standard for ERISA retiree benefit claims (or, in the alternative, adopt a clear and express vesting standard). Not only does this standard comport with federal labor policy, it also establishes a bright-line test that will curb inconsistent outcomes and lead to predictability in the arena of retiree benefits litigation.

II. A "REASONABLE SUGGESTION" OR "REASONABLY SUSCEPTIBLE" STANDARD IS NOT CONSISTENT WITH NATIONAL LABOR POLICY

Both the Second and Seventh Circuits have adopted standards that require the contract language at issue to "reasonably support" an intent to vest retiree benefits. *See Joyce*, 171 F.3d at 135 ("[We] will not infer a binding obligation to vest benefits absent some language that itself reasonably supports that interpretation."); *Rosetto v. Pabst Brewing Co.*, 217 F.3d 539, 547 (7th Cir. 2000) ("If there is language in the agreement to suggest a grant of lifetime benefits, and the suggestion is not negated by the agreement read as a whole, the plaintiff is entitled to a

trial."). This "reasonable suggestion" standard, however, is simply another way of stating ambiguity is sufficient for vesting and, for the reasons discussed below, this standard would likely result in a continuation of *Yard-Man*. Since this standard is a deviation from the clear and unmistakable waiver standard adopted as a matter of federal common law by the Court, it should be rejected.

A. The "Reasonable Suggestion" Standard Allows For Further Variation & Disarray Among The Courts of Appeal

As noted in part I.D above, not only does the evidentiary standard necessary to show an intent to vest vary across jurisdictions, the contract interpretation methods utilized by the appellate courts to discern an intent to vest also differ, regardless of the standard applied. This lack of uniformity has allowed the appellate courts (primarily the Sixth Circuit) to employ a hodgepodge of interpretative tools and create forced, results-driven rules of contract construction. The adoption of a clear and express waiver standard, however, would eliminate the need for courts to engage in such "interpretive gymnastics" *see Diehl v. Twin Disc, Inc.*, 102 F.3d 301, 307 (7th Cir. 1996), as it would require the labor agreement to contain clear language indicating an employer's intent to waive its ERISA rights and to vest retiree health benefits.

1. The Sixth Circuit's Pension Tying Rule Is Not Indicative Of Vesting

The Sixth Circuit has attempted to bolster its *Yard-Man* inference by holding that "tying" eligibility for retiree health insurance to eligibility for pension benefits

suggests an intent to vest benefits. *See Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 656 (6th Cir. 1996). This rule is unique to the Sixth Circuit, as other appellate courts have either expressly rejected the concept of tying welfare benefits to the receipt of a pension as indicative of vesting or simply ignored this factor in their vesting analysis. *See, e.g., Joyce*, 171 F.3d at 134 (tying benefits eligibility to pension eligibility could not "reasonably be read as binding [the employer] to vest the benefits at issue"); *John Morrell & Co. v. UFCW*, 37 F.3d 1302, 1307-08 (8th Cir. 1994) (fact that retiree spousal insurance was contingent on selecting a particular type of pension did not indicate an intent to vest).

This rule of construction–concocted out of whole cloth by the Sixth Circuit–in no way reveals a clear and express intent to vest retiree healthcare benefits. As discussed above in Part I.C.1, the tying rule is tantamount to automatic vesting; left unchecked, "tying" could arguably satisfy the "reasonably supports" standard. ERISA, however, intentionally differentiates between welfare benefits and pension benefits for vesting purposes and grants employers the freedom to offer, modify, or terminate welfare benefits for any reason and at any time. *See Curtiss-Wright Corp.*, 514 U.S. at 78. The fact that an employer offers pension-eligible employees the opportunity to continue health insurance benefits into retirement does not override the statutory rights in ERISA, nor does it give rise to a "reasonable suggestion" that an employer relinquished that right. Regardless of the standard adopted, the Court should make clear that the Sixth Circuit's tying analysis does not survive, as it is in plain contravention of the text and purpose of ERISA. *See United Steel, Paper & Forestry, Rubber, Mfg. Energy,*

Allied Indus. & Service Workers Int'l Union, AFL-CIO-CLC v. Kelsey Hayes Co., 750 F.3d 546, 563 (6th Cir. 2014) (Sutton, J., dissenting) (questioning whether Sixth Circuit's tying analysis and analogy between pensions and retiree healthcare benefits was "a good idea in the first place").

2. The Sixth Circuit's "Specific v. General" Durational Clause Rule Should Be Rejected

The Sixth Circuit also draws a distinction between specific and general durational clauses, giving effect only to those clauses that expressly extinguish retiree healthcare benefits. *See, e.g.*, *Noe v. PolyOne Corp.*, 520 F.3d 548, 554 (6th Cir. 2008) ("Absent specific durational language referring to retiree benefits themselves, courts have held that the general durational language says nothing about those retiree benefits."); *Maurer*, 212 F.3d at 917-18 (durational clause that explicitly terminated insurance agreement conferring retiree benefits was a "general durational provision [] for the entire agreement" and was not "meant to include retiree benefits"). Applying the Sixth Circuit's rule, a court practically must find anti-vesting language in the agreement, elsewise the language reasonably suggests retiree healthcare benefits are vested. This rule, moreover, in no way aims at discerning the intent of the parties. Rather, it blatantly and one-sidedly rejects a perfectly reasonable interpretation of the impact of durational clauses on retiree benefits.

In stark contrast, both the Court and several Circuits have acknowledged–if not embraced–the default rule that all benefits under a negotiated agreement expire along with the agreement pursuant to its general durational

clause. *See Litton Fin. Printing Div. v. NLRB*, 501 U.S. 190, 207 (1991) ("contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement . . ." and an agreement must "provide[] in explicit terms" that "certain benefits continue after the agreement's expiration"); *Joyce*, 171 F.3d at 135 (fact that contract's retiree benefit provisions did not contain specific durational limitations of no import where plaintiff failed to identify language implying vesting); *Baldwin v. Motor Components*, 155 F. App'x 16, 18 (2d Cir. 2005) (agreeing "with the district court's conclusion that the effective dates of the agreements were clear and that, since the [CBAs] had expired, appellee . . . was free to alter the benefits plans at will") (unpublished); *Skinner*, 188 F.3d at 141 (interpreting contract as providing retiree benefits through its expiration date "appears to be the more reasonable [interpretation] in light of the durational provisions in all of the CBAs"); *Int'l Chem. Workers v. PPG Indus.*, 236 F. App'x 789, 793 (3d Cir. 2012) (benefits did not vest where the "CBAs all included termination provisions which provided that the terms of the CBA remained in effect until the expiration of the CBA") (unpublished); *Senn*, 951 F.2d at 816 ("The default rule in this Circuit is that entitlements established by [CBAs] do not survive their expiration or modification . . . the logical interpretation under our rule is that benefits 'will continue' for the duration of the contract."); *Anderson v. Alpha Portland Indus.*, 836 F.2d 1512, 1519 (8th Cir. 1988) ("It would render the durational clauses nugatory to hold that benefits continue for life even though the agreement which provides the benefits expires on a certain date.").

In fact, the Sixth Circuit has adopted the default rule that contractual obligations expire upon the termination of the underlying agreement, but has recognized that

certain obligations may survive termination when a labor agreement expressly and unambiguously provides a lifetime guarantee. *See Heheman v. E.W. Scripps Co.*, 661 F.2d 1115, 1121 (6th Cir. 1981) (provision that explicitly guaranteed employment "for the remainder of [employees'] working lives" survived expired CBAs); *see also Int'l Bhd. of Teamsters, Local 1199 v. Pepsi-Cola Gen. Bottlers, Inc.*, 958 F.2d 1331, 1334 (6th Cir. 1992) ("Generally, an employer's contractual obligations under a [CBA] cease upon termination of the agreement . . . *rights may survive the expiration of the collective bargaining agreement if the agreement provides in explicit terms that certain benefits continue after the agreement's expiration.*") (emphasis added). The Sixth Circuit, however, inexplicably and unjustifiably failed to apply this default rule to retiree benefits.

The Sixth Circuit's rule differentiating between specific versus general durational clauses should be rejected. Once again, the Sixth Circuit has devised a minority rule of construction specific to retiree benefits vesting that is at odds with its own precedent and with the common law of labor agreements developed by the Court.

3. Various Sixth Circuit Panels Have Inconsistently Applied *Yard-Man*

In applying its contract interpretation principles, the Sixth Circuit has been anything but consistent. The Sixth Circuit was forced, several years after issuing *Yard-Man*, to clarify that it did not create a presumption, but merely an inference. *Compare UAW v. BVR Liquidating, Inc.*, 190 F.3d 768, 772-73 (6th Cir. 1999) (*Yard-Man* principles are a "presumption" in favor of vesting) *with Maurer*, 212

F.3d at 917 (*Yard-Man* is not a legal presumption) *and Reese*, 574 F.3d at 321 (*Yard-Man* is a "nudge" or "thumb on the scales"). In application, this is pure semantics. Notwithstanding the Sixth Circuit's assurances to the contrary, *Yard-Man* effectively shifts the burden of proof to the employer. If vesting can be inferred despite contractual silence as to duration, the employer must essentially prove a negative–namely, its intent *not* to vest benefits for life and at unalterable levels. *See Noe*, 520 F.3d at 568 (Sutton, J., dissenting) (*Yard-Man* has "become a clear-statement rule. Unless a company can point to explicit language in the relevant agreement stating that 'retiree benefits' terminate at a particular date or do not vest, the benefits seem to vest as a matter of law. What we continually disclaim presuming we continually seem to presume.").

Furthermore, although *Yard-Man* cautioned against interpreting contracts so as to render any promise to provide retiree benefits "illusory," the Sixth Circuit has since held that express reservations-of-rights clauses allowing the termination or modification of retiree benefits in collectively-bargained health plans have no such "illusory" effect. *Compare Yard-Man*, 716 F.2d at 1480 (interpretation that retiree benefits expired with agreement rendered benefit for certain employees "illusory") *with Witmer*, 694 F.3d at 775-76 (no vesting where plan contained both reservation of rights language and a promise to provide retiree benefits) *and Maurer*, 212 F.3d at 919 (promise to provide retiree benefits circumscribed by reservation of rights clause in plan SPD).

B. The Clear & Express Standard Lends Clarity To Vesting Law & Should Be Adopted

As the above cases demonstrate, adoption of a "reasonably susceptible" or "reasonable suggestion" standard would not remedy the confusion and inconsistency surrounding vesting law. This standard is simply too vague to provide adequate guidance to the parties (either union or employer) as to the contract language sufficient to waive ERISA rights and convey an intent to vest retiree benefits. Ultimately, such a standard would allow the Sixth Circuit to continue to apply results-driven contract interpretation methods under the guise that the labor agreement contained language "reasonably suggestive" of vesting. It is thus critical to the national policy embodied in ERISA and to the development of a consistent federal common law that this Court apply the clear and unmistakable waiver standard to retiree welfare benefits, or alternatively adopt the Third Circuit's clear and express vesting standard.[13]

C. Analysis of Extrinsic Evidence Should Be Subject To A Clear, Express, & Unmistakable Standard

Amici recognize the (rare) possibility that contract language may contain a latent ambiguity as to whether an employer has clearly, expressly, and unmistakably agreed to waive its ERISA termination and modification rights and thereby vest retiree benefits, thus necessitating

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13. As noted above, an explicit reservation of these ERISA rights is unnecessary, as rights created by statute need not be embodied in an agreement. *See Timken*, 325 F.2d at 751.

resort to extrinsic evidence. *See, e.g.*, *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779, 784-85 (7th Cir. 2005) (finding ambiguity as to vesting in light of "lifetime" language present in three separate plan documents); *Diehl*, 102 F.3d at 306 (agreement stated retirees "entitled [to health benefits] for the lifetime of the pensioner"); *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90, 98 (2d Cir. 2001) (references to "lifetime" life insurance benefits in early retirement plans were "ambiguous and susceptible to interpretation as a promise of vested benefits"). *Cf. Skinner*, 188 F.3d at 142 (providing, in dicta, examples of contract language that could clearly and expressly indicate vesting, including statements such as "retiree benefits 'will continue for the life of the retiree' or that they 'shall remain unalterable for the life of the retiree'").

This Court should instruct that when a court looks outside the collective bargaining agreement, the clear and express standard remains applicable. Thus, like the contract language, the extrinsic evidence also must establish that the employer clearly and unmistakably relinquished its right to terminate or modify such benefits and intended to vest retiree benefits. *Cf. Local Union 36, IBEW v. NLRB*, 706 F.3d 73, 84 (2d Cir. 2013) (extrinsic evidence must establish clear and unmistakable waiver of statutory right); *OCAW, Local 1-547 v. NLRB*, 842 F.2d 1141, 1143 (9th Cir. 1988) (same). Thus, when the extrinsic evidence points in both directions, the clear and unmistakable waiver standard has not been met.

Under the current state of the law, once a written agreement has been deemed ambiguous as to vesting, the federal courts have turned to a host of factors to determine whether the parties intended that retiree

benefits would survive termination of the applicable labor agreement. Extrinsic evidence of intent to vest includes, for example, evidence of past changes to retiree benefits; representations in summary plan descriptions and other participant notices and communications; contract proposals and offers; negotiations minutes; and testimony from company and union bargaining representatives. [14] *See generally Zino*, 2013 U.S. Dist. LEXIS 121750; *Bender v. Newell Window Furnishings, Inc.*, 681 F.3d 253, 267-68 (6th Cir. 2012) (summarizing extrinsic evidence considered). Such evidence, taken together, must reveal a clear and unmistakable waiver of the employer's right to change or discontinue benefits.

Adoption of a clear and unmistakable waiver or clear and express vesting standard will greatly reduce the need for extrinsic evidence. This, in practice, makes sense. The reality in the Midwest is that plants, and for that matter, entire corporations have ceased to exist. On the other

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14. This last category of extrinsic evidence–oral testimony–warrants further discussion. ERISA requires "every employee benefit plan . . . be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Oftentimes in retiree vesting cases, witness testimony aims to interpret or otherwise explain the terms of a written benefit plan, based on the parties' contemporaneous oral representations and negotiations. Such testimony should be accorded little weight, as oral assurances and other extra-plan promises carry little weight in ERISA cases and cannot alter the written terms of a plan. *See, e.g., Mello v. Sara Lee Corp.*, 431 F.3d 440, 447 n.6 (5th Cir. 2005); *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litig.*, 58 F.3d 896, 902 (3d Cir. 1995) (right to vested retiree benefits must be stated in clear and express language and "[t]he written terms of the plan documents control and cannot be modified or superseded by . . . oral undertakings").

side of the ledger, local unions and international unions have ceased to exist. The task of finding negotiations minutes, contract proposals, plans, SPDs, participant communications, enrollment forms (all dating back decades) and then locating witnesses with knowledge is Herculean, but more frequently akin to Sisyphean. *See, e.g.*, *Bender*, 681 F.3d at 257 (former UAW Local 797 plant owned by Kirsh Company, then by a division of Cooper Industries, then by Newell); *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, 1069 (6th Cir. 2008).(plants spun-off by Rockwell as Meritor Auto; Meritor merged with Arvin Industries); *Yolton*, 435 F.3d at 574 (JI Case, which became subsidiary of Tenneco, then spun-off as Case Equipment now known as CNH America; remainder of Tenneco merged with El Paso Natural Gas); *McCoy v. Meridian Auto. Sys., Inc.*, 390 F.3d 417, 419 (6th Cir. 2004) (plant owned by Rockwell International, Cambridge Industries, and Meridian).

The record at Hoover is similarly tortured. Hoover was purchased by Chicago Pacific Railroad in 1985 and then by Maytag in 1989. In 2006, Whirlpool purchased Maytag and then sold Hoover to TTI in 2007. In 2011, after Whirlpool announced its intention to harmonize the Hoover retirees' benefits with its own existing benefit plans, litigation commenced. Whirlpool thus had to locate documents covering a bargaining relationship of nearly 30 years, during which time three separate companies owned and operated Hoover. It goes without saying that the retention of documentary evidence over such an extended period of time in light of corporate reorganizations was of paramount concern. Adoption of a clear and unmistakable waiver standard will decrease–if not eliminate–the need to locate and review years upon years of documentary evidence or to tap into faded witness memories.

CONCLUSION

For all the above reasons, Whirlpool respectfully requests the Court reverse the Sixth Circuit's decision in *Tackett v. M&G Polymers USA, LLC* and find that a clear, express, and unmistakable standard applies to an employer's agreement via collective bargaining to waive its ERISA-conferred rights to modify and terminate welfare benefit plans and to vest retiree healthcare benefits for a retiree's lifetime at fixed, unalterable levels.

Dated: July 24, 2014

Respectfully submitted,

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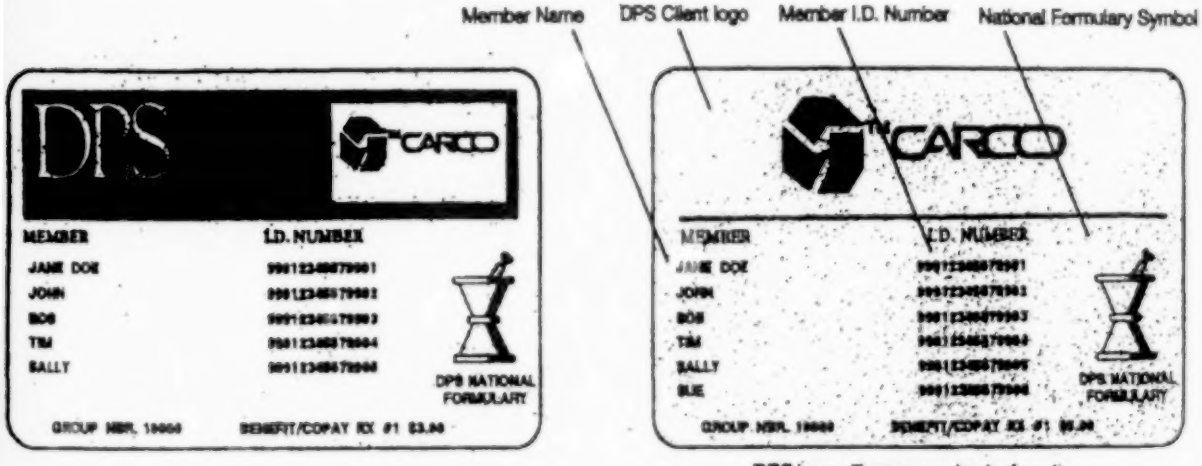
EXHIBIT

DPS DIVERSIFIED PHARMACEUTICAL SERVICES

Questions may be directed to:
1-800-233-8065

This information is provided to your pharmacy as part of its agreement with DPS. This information applies to all persons covered by the DPS National Formulary. DPS National Formulary customers will carry the following types of I.D. cards



DPS logo will appear on back of card.

Note the following Non-Formulary medications and the respective **Formulary Alternative(s)**. The freeform messages delivered on-line correspond to the Formulary products listed below.

When a Non-Formulary medication is prescribed, you are required to contact the physician to request a change to a Formulary Alternative. Thank you for your compliance with the DPS National Formulary.

Non-Formulary	Formulary Alternatives
Accupril	**Altace, Lotensin**
Accupril	**Monopril**
Alupent	**Metaprel**
Aventyl	**Pamelor**
Axid	**Zantac, Tagamet**
Brevicon	**Modicon**
Bricanyl	**Brethine**
Cardura	**Hytrin**
Cefzil	**Ceftin, Suprax**
Chenix	**Actigall**
Clomid	**Serophene**
Colestid packets	**colestipol bulk**
Deponit	**Nitro-Dur**
Deponit	**Transderm-Nitro**
Desoxyn gradumet	**Desoxyn**
Doryx	**doxycycline**
Duricef	**cephalexin HCl**
E-Mycin 333	**EryTab 333**
Epo	**Procrit**
Fioricet	**Esgic**
Hismanal	**Seldane**
Imodium	**Imodium A/D (otc)**
Isoptin SR	**Calan SR**
Keflet	**cephalexin HCl**
Keftab	**cephalexin HCl**
Kerlone	**atenolol**
Levlen	**Nordette**

Non-Formulary	Formulary Alternatives
Lortab	**generic Vicodin (notES)**
Micronase	**Diabeta**
Minitran	**Nitro-Dur**
Minitran	**Transderm-Nitro**
Monodox	**doxycycline**
Mycrox	**Diulo, Zaroxolyn**
Natalins RX	**Zenate, Materna**
Nitrodisc	**Nitro-Dur**
Nitrodisc	**Transderm-Nitro**
Norinyl	**Ortho-Novum**
Normodyne	**Trandate**
Noroxin	**Cipro, Floxin**
Pepcid	**Zantac, Tagamet**
Prenate-90	**Zenate, Materna**
Proventil	**Ventolin**
Questran bars	**Questran bulk**
Questran packets	**Questran bulk**
Stuartnatal 1+1	**Zenate, Materna**
Sumycin tablets	**tetracycline caps**
Tenex	**Wytensin**
Tofranil PM	**imipramine HCl**
Trilevlen	**Triphasil**
Trinalin	**Tavist-D**
Trinalin	**Seldane-D**
Vancenase, AQ	**Beconase, AQ**
Vanceril	**Beclovent**
Vicodin ES	**generic Vicodin (notES)**

Date: 4-01-92

DPS DIVERSIFIED PHARMACEUTICAL SERVICES

Questions may be directed to:
1-800-233-8065

DPS NATIONAL FORMULARY

The following drugs are included in the DPS National Formulary. Categories listed represent the most commonly utilized prescription medications. The list is not all inclusive nor does it guarantee coverage, but represents an abbreviation of the patient's prescription drug coverage.

ANTIBACTERIALS

$	*amoxicillin	$$	*dicloxacillin
$	*ampicillin	$$	Eryped
$	*Bactrim	$$	*Pediazole
$	*EES	$$$	Augmentin
$	*Eryc	$$$	Ceftin
$	*Erytab	$$$	Furadantin
$	*Erythrocin	$$$	Macrodantin
$	Gantrisin	$$$	PCE
$	*Keflex	$$$	Suprax
$	*penicillin VK	$$$$	Ceclor susp.
$	*Septra	$$$$	Cipro
$	*tetracycline	$$$$	Floxin
$	*trimethoprim	$$$$	Minocin
$	*Vibramycin		

ANTIULCER DRUGS

$$$	Zantac	$$$$	Carafate
$$$$	Tagamet	$$$$$	Prilosec

ANTIHISTAMINES

$	*Atarax	$$	Polaramine
$	*Benadryl	$$$	*PBZ, SR
$	*Periactin	$$$$	Seldane
$	*Phenergan	$$$$	Tavist
$	*Vistaril		

ANTIHISTAMINE/DECONGESTANTS

$$	Bromfed, PD	$$$	Rondec, TR
$$	Nolamine	$$$$	Tavist-D
$$$	Kronofed-A Jr	$$$$	Seldane-D

DECONGESTANTS

$$	*Entex LA	$$	Entex

ORAL ANTIFUNGALS

$	*nystatin	$$$$	Nizoral
$$	Grifulvin	$$$$$	Diflucan
$$	Mycelex troche		

ACE INHIBITORS

$$$	Altace	$$$$	Prinivil, Zestril
$$$	Lotensin	$$$$$	Capoten
$$$	Monopril	$$$$$	Vasotec

BETA BLOCKERS

$	Blocadren	$$	Trandate
$	*Inderal	$$$	Visken
$$	Inderal LA	$$$$	*Tenormin
$$	Lopressor	$$$$$	Corgard
$$	Sectral		

CALCIUM BLOCKERS

$	*Calan, Isoptin	$$$	Cardene
$$	Calan SR	$$$	Cardizem, SR, CD
$$	Dynacirc	$$$	*Procardia, Adalat
$$	Verelan	$$$$	Procardia XL

ANTILIPEMICS

$	*Atromid-S	$$$$	Pravachol
$	Nicobid (otc)	$$$$	Questran
$$$	Colestid	$$$$	Questran Light
$$$	Lorelco	$$$$$	Mevacor
$$$$	Lopid		

BETA-AGONISTS

$	*Alupent tabs, syrup	$$$	Maxair
$	*Metaprel tabs, syrup	$$$	Metaprel inhalers
$$	*Proventil tabs	$$$	Proventil repetabs
$$	*Ventolin tabs	$$$	Ventolin inhalers
$$$	Brethaire	$$$	Ventolin soln, syrup
$$$	Brethine		

ORAL HYPOGLYCEMICS

$	*Diabinese	$$$	Diabeta
$	*Orinase	$$$	Tolinase
$$	Dymelor	$$$$	Glucotrol

NSAIDS

$	*ibuprofen	$$	Voltaren
$	*Indocin, SR	$$$	Anaprox, DS
$$	*Clinoril	$$$	Anaaid
$$	Children's Advil	$$$	Naprosyn
$$	*Meclomen	$$$	Orudis
$$	Pediaprofen	$$$	Tolectin, DS
$$	Relafen	$$$$	Lodine

ORAL CONTRACEPTIVES

For patients with OC coverage, the following are included in the formulary:

$	Lo/Ovral	$$$$	Loestrin
$	Modicon	$$$$	Norlestrin
$	Nordette	$$$$	Ovcon
$	Ortho Novum (All)	$$$$	Ovulen
$	Trinorinyl	$$$$$	Enovid
$	Triphasil	$$$$$	Ovral
$$	Demulen		

ESTROGENS

$$	Premarin	$$$	Ogen
$$$	Estrace	$$$$	Estraderm

VAGINAL ANTIFUNGALS

$	*nystatin	$$$	Monistat-3, Dual
$$	Gyne-Lotrimin (otc)	$$$	Mycelex-G
$$	Monistat-7 (otc)	$$$	Terazol
$$$	Femstat		

NASAL CORTICOSTEROIDS

$$	Nasacort	$$$	Beconase, AQ
$$	Nasalide	$$$$	Decadron Turbinaire

KEY:
$ = Relative cost index
* = Generic available
otc = Available without a prescription

Date: 4-01-92

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